10-27-2014

An Examination of Coalition Functioning and Use of Evidence-Based Practices: A Case Study of Four Community Substance Abuse Coalitions

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by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Public Health
Department of Community and Family Health
with a concentration in Behavioral Health
College of Public Health
University of South Florida

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Date of Approval:
October 27, 2014

Keywords: EBP, implementation, drugs, prevention

ACKNOWLEDGMENTS

The successful completion of this thesis could not have occurred without the help from several individuals. I would like to acknowledge my committee for all of their help and support throughout this process. Thank you, Dr. Massey for leading this committee and for your guidance and direction. I would not have been able to complete this project without your ongoing support, your availability and patience to answer all of my questions, and your willingness to share your insights and experiences. Thank you, Dr. Baldwin for your support and patience throughout this process. Thank you, Dr. Moore for exposing me to the work of community substance abuse coalitions, for answering all of my questions, and for helping me understand and connect with these community organizations. I would not have been involved with this type of research if it was not for you.

I would also like to acknowledge Dr. Armstrong for her extensive help and guidance with the qualitative data analysis and Dr. Young for his help connecting me with these coalitions and for his expert review of my study instruments. Finally, I would like to acknowledge all of the participating coalitions for their cooperation. A special acknowledgement goes out to Ellen Snelling for her availability to meet with me, provide feedback, and answer all of my questions about community coalitions. Thank you all for everything.

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ABSTRACT

Background

There has been a recent expansion of community-based coalitions to address issues related to youth substance use. Research on their overall effectiveness, however, has produced mixed results. Recommendations to improve coalition success have emphasized the high-quality implementation of evidence-based programs targeting specific community needs. Coalitions vary extensively, however, in their organization and functioning. In addition, the lack of a universally accepted theoretical framework to understand coalition functioning has led to inconsistencies in the coalition research and the specific constructs used to describe coalition functioning.

Purpose of the Study

To address these gaps, the current study used a case study approach to describe the organization and functioning of four local substance abuse coalitions and to identify factors related to coalition high-quality implementation of evidence-based programs.

Methods

Using constructs based on Community Coalition Action Theory, the current study used coalition member surveys and key leadership interviews to produce separate case study descriptions of four participating community substance abuse coalitions. An exploratory factor analysis was conducted to examine the structure of the survey measure. Univariate statistics were

used to describe coalition functioning and attitudes toward evidence-based practice and implementation. One-way analysis of variance tests were employed to examine differences across the coalitions and Pearson's product-moment correlations were used to identify coalition characteristics associated with attitudes toward evidence-based practice. A thematic analysis of interview data was conducted for an in-depth examination of coalition functioning and perceptions of evidence-based practice.

Results

Coalition members and leaders reported high levels of functioning across all of the included domains. However, several differences in coalition background and structure were discussed. Community support was described as a major functioning challenge across both surveys and interviews. Interview results also revealed several different coalition belief patterns surrounding evidence-based practice and quality implementation. Coalition members and leaders generally indicated positive attitudes toward the use of evidence-based prevention programs and strategies. However, varying levels of knowledge and experience with evidence-based practices was identified across interviews. Interviews also highlighted several factors that influence coalition decision-making and identified several perceived challenges associated with the use of evidence-based practices. Results include a discussion of coalition knowledge, perceptions, and experiences with program implementation.

Conclusions and Implications

Taken together, these findings form a basis for better understanding the current environment surrounding community substance abuse coalition functioning and implementation

of evidence-based practices. Several factors were shown to influence coalition decision-making processes and overall functioning. In addition, the present study highlights strengths and gaps related to coalition leadership knowledge, attitudes, and implementation of evidence-based programs and strategies. These identified relationships can be used to guide future research and community practice. With their growing popularity, it is likely that community coalitions will take on a major role in future community-based prevention efforts across the country. As such, there is a need to design substance abuse prevention programming with coalitions in mind and to identify alternative avenues to disseminate information surrounding community-focused evidence-based practices. Identifying new ways to measure and build coalition processes, leadership skills, and structures could result in greater coalition capacity to plan for and support prevention activities, including use of evidence-based practices.

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CHAPTER ONE:

STATEMENT OF THE PROBLEM

Youth substance use is a multidimensional issue, influenced by a variety of individual, peer, family, school, and community experiences. Prevention efforts aimed at addressing the risk and protective factors that influence substance use across multiple levels have been suggested as necessary for enacting widespread and long-term change (Holder, 2002). Research identifying these influencing factors has led to the development of prevention and intervention efforts with empirical support for their effectiveness (Hawkins, Catalano, & Arthur, 2002). Despite these advancements in evidence-based programs (EBPs), the translation of these programs to practice has been slow-going. In addition, even when programs are adopted in community practice, issues relating to implementation can inhibit their success (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

Community-based efforts have been one strategy for addressing the complex issue of youth substance use, through the employment of multiple strategies at several levels to address the variety of factors influencing youth use (Wandersman & Florin, 2003). Through the use of multiple strategies, community-based efforts aim to reach many individuals and achieve sustainable community-wide reductions in substance use. The establishment of community coalitions, comprised of diverse community stakeholders, has been a popular approach for enacting these community-wide efforts and translating EBPs into real-world practice. Involvement of community members in the selection, implementation, and monitoring of substance use prevention efforts may be related to increased community buy-in and relevance of

prevention activities to unique community needs, resources, and values (Wandersman & Florin, 2003). Community collaboration through such coalitions may also promote inter-agency sharing of information and resources, minimizing the potential for duplication of services and enhancing program implementation and sustainability (Fagan, Hawkins, & Catalano, 2011). Research has found that community mobilization efforts can be effective in reducing rates of alcohol and drug use, along with associated outcomes, at the community level (Flewelling et al., 2005; Hawkins, Oesterle, Brown, Abbott, & Catalano, 2014; Hawkins, Oesterle, Brown, & et al., 2009; Redmond et al., 2009; Spoth, Redmond, et al., 2007).

Although community coalitions have become a common component of many effective community-based prevention strategies, not all coalitions are successful in their efforts to reduce rates of substance use (Hallfors, Cho, Livert, & Kadushin, 2002; Kreuter, Lezin, & Young, 2000; Roussos & Fawcett, 2000; Yin, Kaftarian, Yu, & Jansen, 1997). Two examples, the *Fighting Back Against Substance Abuse* initiative (Hallfors et al., 2002) and the *Community Partnership Program* (Yin et al., 1997), failed to produce desired reductions in substance use despite their intentions and adequate funding. Simply gathering community stakeholders to tackle substance use issues is not enough to produce the desired changes (Fagan et al., 2011). There are certain factors relevant to the coalition that can impact their effectiveness. Hallfors and colleagues (2002) made several recommendations for successful coalitions, including: 1) establishing clear, focused, and manageable goals, 2) choosing research-based programs, and 3) paying careful attention towards monitoring the implementation, dose, and quality of chosen programs.

Since the Hallfors et al. (2002) report, there have been several efforts to apply these recommendations to practice. The *Community Youth Development Study* was able to successfully apply the Communities that Care (CTC) prevention system across 12 communities, promoting

coalition selection and adoption of EBPs implemented with high levels of fidelity (Fagan, Hanson, Hawkins, & Arthur, 2008a, 2008b, 2009). When coalitions are organized around a prevention system that promotes the use of EBPs, successful adoption and high-quality implementation can occur. However, less is known about the factors that promote EBP adoption among coalitions operating outside of these frameworks. In addition, the vast differences in organization and functioning across coalitions make it unlikely that these prevention systems can be consistently implemented successfully without adaptation. Even within these prevention frameworks, variation has been shown to exist in coalition adoption of EBPs (Shapiro et al., 2013). A need currently exists to understand differences in coalition development and functioning and how these differences may impact coalition use and implementation of EBPs.

CHAPTER TWO:

INTRODUCTION

Adolescent Substance Use

Substance use is a serious public health concern, associated with a multitude of costly individual and social consequences. In the United States, tobacco (435,000), alcohol consumption (85,000), and illicit drug use (17,000) were attributable to an estimated 537,000 deaths in 2000 (Mokdad, Marks, Stroup, & Gerberding, 2004), representing the largest proportion of preventable deaths that year. In 2002, it was estimated that drug use cost the United States $180.9 billion in health care costs, productivity losses, and other costs (Office of National Drug Control Policy, 2004). Numerous studies have identified adolescence as a particularly sensitive period for the development of alcohol and drug use issues (Merikangas, 2010; Palmer et al., 2009; Swendsen, Burstein, Case, & et al., 2012). One recent epidemiological study, using a nationally representative sample of adolescents, reported that by late adolescence, 78.2% of youth had consumed alcohol, 47.1% had reached regular drinking levels, and 15.1% met criteria for lifetime alcohol abuse (Swendsen et al., 2012). This same study found that by late adolescence, 42.5% of youth reported lifetime use of illicit drugs and 16.4% met criteria for abuse of illicit drugs (Swendsen et al., 2012). The median age of onset for first use of alcohol was 13 years-old, with a median age of 14 years-old for regular use or abuse (Swendsen et al., 2012). For illicit drugs, the median age for first use was 14 years-old, with a median age of 15 years-old for abuse (Swendsen et al., 2012).

Early age of onset of alcohol and drug use is also associated with worse outcomes, including a number of social and health consequences. Adolescent substance users are more likely to drop out of school (Townsend, Flisher, & King, 2007), and engage in other risky behaviors, such sexual risk-taking (Tapert, Aarons, Sedlar, & Brown, 2001). In addition, alcohol and drug use is associated with an increased risk for unintentional injury, suicide, and violence, the three leading causes of death among adolescents aged 10 to 18 (Centers for Disease Control and Prevention, 2010). Substance use in adolescence can also contribute to problems in adulthood and can be linked to changes in brain development (Squeglia, Jacobus, & Tapert, 2009). Individuals who initiate substance use in adolescence are more likely to experience drug dependence problems (Palmer et al., 2009) and be diagnosed with a co-morbid mental health disorder (Brook, Richter, & Rubenstone, 2000) in adulthood than individuals who initiate substance use as adults.

Targets for Prevention

It is clear that prevention efforts targeting the vulnerable developmental period of adolescence will have the greatest impact on alcohol and drug-related problems in the United States. The National Institute on Drug Abuse (NIDA) has emphasized 16 principles of effective prevention, centering largely on addressing the risk and protective factors that have been shown to influence adolescent substance use (National Institue on Drug Abuse, 2003). Risk factors refer to the precursors of a negative health event, like substance use, or those variables that occur before the use and are associated with an increased probability of its occurrence (Hawkins, Catalano, & Miller, 1992). Protective factors, on the other hand, refer to factors that mediate or moderate the effects of exposure to risk, decreasing the likelihood of experiencing a negative

health event (Hawkins et al., 1992). In prevention science, it is assumed that eliminating or reducing exposure to risk factors, while enhancing protective factors, will prevent or delay the occurrence of a negative health event, such as substance use (Hawkins et al., 2002).

For adolescent substance use, risk and protective factors have been identified across a variety of domains, including those related to the community (e.g., availability of drugs, community policies and norms, community disorganization), family (e.g., family history, level of conflict, parental attitudes), school (e.g., academic achievement, school attachment), peers (e.g., peer behavior, peer attitudes), and within the individual (e.g., individual attitude, early initiation) (Hawkins et al., 2002). As demonstrated by the range of factors identified above, adolescent substance use is a complex issue, influenced by a variety of factors across multiple ecological domains. It has been suggested that comprehensive efforts, employing evidence-based interventions across multiple levels of adolescent risk, is most effective for preventing alcohol and drug-related problems (Hawkins et al., 2002).

Evidence-Based Programs

The past couple decades have witnessed a surge in the development of interventions to address adolescent substance use, with the recognition that behavioral problems can be prevented. Evidence-based programs (EBPs) refer to interventions that have empirical support for their effectiveness based on rigorous evaluations in experimental or quasi-experimental studies. However, despite the identification of associated risk and protective factors and the development of effective interventions to address them, adolescent substance use remains prevalent across the United States. It was soon recognized that the development of effective interventions was not sufficient to assure their actual implementation; an issue in translation

exists. Balas and Boren (2000) quantified this translation issue with their frequently quoted statement that "it takes 17 years to turn 14 percent of original research to the benefit of patient care" (Balas & Boren, 2000).

In response to this realization, several attempts have been made to encourage the adoption of EBPs in schools and communities to prevent adolescent substance use. Governmental agencies have reacted by providing incentives and funding opportunities to increase the uptake of EBPs in practice. One example is the U.S. Department of Education's 1998 establishment of the *Principles of Effectiveness*, with a requirement that schools implement research-based programs to receive Safe and Drug Free Schools (SDFS) funding, the largest funding source for school-based drug prevention at the time (U.S. Department of Education, 1998). However, even with this requirement, many school-based substance use prevention efforts still relied on programs without research support (Ennett et al., 2003; Hallfors & Godette, 2002; Ringwalt et al., 2002). One evaluation reported that only 26.8% of all schools were using an EBP in 1999 (Ringwalt et al., 2002). Several agencies have also attempted to create their own databases of EBPs to facilitate provider selection and adoption of appropriate programs. Examples include the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices (NREPP) (See at http://www.nrepp.samhsa.gov/) and the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado's Blueprints for Healthy Student Development (See at http://www.colorado.edu/cspv/blueprints/).

In addition to issues related to EBP uptake, other challenges inhibiting successful program implementation exist, further contributing to the gap between research and practice. One study reported that although the *Principles of Effectiveness* policy resulted in a greater

number of schools adopting EBPs, only 19% of schools were implementing EBPs with attention towards program fidelity, decreasing the likelihood that programs were producing their desired effects (Hallfors & Godette, 2002). Many factors have been shown to influence program implementation, including those related to the community agency or practitioner and factors related to specific aspects of the program itself (Fixsen et al., 2005). Further, many EBPs have been developed and evaluated under highly controlled research settings, with little attention to how implementation will look in a less controlled community setting (Glasgow, Klesges, Dzewaltowski, Bull, & Estabrooks, 2004). With this knowledge, it is clear that actions to increase the translatability and high-quality implementation of EBPs to community settings are necessary (Wandersman, 2003).

Community-Centered Approach to Prevention

Community-based efforts have been one strategy for addressing the complex issue of youth substance use, employing multiple strategies at several levels to address the variety of factors influencing use (Wandersman & Florin, 2003). Through the use of multiple strategies, community-based efforts aim to reach many individuals and achieve sustainable community-wide reductions in adolescent substance use. A community-centered approach to substance use prevention has also been suggested as a method to help bridge the science to practice gap (Wandersman, 2003). Involving community members themselves in the EBP research, selection, and implementation process can lead to increased community buy-in and relevance of prevention activities to unique community needs, resources, and values (Wandersman & Florin, 2003) and can build a community's capacity to address other community health or social issues (Butterfoss & Kegler, 2009). In turn, community involvement can help: 1) increase the generalizability of

research findings to real-world practice, 2) increase the likelihood that research-based programs are adopted and implemented correctly, and 3) ensure that selected EBPs will fit the community's unique needs and values (Butterfoss & Kegler, 2009). Research on community-centered approaches has found that these mobilization efforts can be effective in reducing rates of alcohol and drug use, along with associated outcomes, at the community level (Flewelling et al., 2005; Hawkins et al., 2014; Hawkins et al., 2009; Redmond et al., 2009; Spoth, Redmond, et al., 2007).

The Rise of Community Coalitions

The establishment of community substance abuse coalitions has been a popular approach for enacting these community-wide efforts and translating EBPs from research to practice. Community coalitions refer to formal partnerships consisting of individuals representing diverse community organizations that come together to work towards a common goal (Feighery & Rogers, 1990). Distinguishing characteristics of a coalition from other types of leadership or partnership groups include: 1) they maximize power through joint action, 2) they avoid service duplication, 3) they pool and share resources, and 4) they develop public support for issues, actions, or unmet needs (Feighery & Rogers, 1990). Community coalitions have been further described as being durable and long-term, mirroring the nature of the community health issues that they aim to address (Butterfoss, Goodman, & Wandersman, 1993).

The year 1990 marked the first national meeting of community substance abuse coalitions in the United States (Butterfoss, 2007). Soon afterwards, the Community Anti-Drug Coalitions of America (CADCA) organization was formed to bring together and build the capacity of community and grassroots substance abuse coalitions across the country (Butterfoss, 2007). Both

government and private sectors joined to support this initiative, creating a multitude of new funding and technical support opportunities. One of the earliest efforts was by the Robert Wood Johnson Foundation (RWJF), who contributed over $88 million from 1990 to 2003 to fund the formation of community coalitions to prevent youth alcohol and drug use in the *Fighting Back* Initiative (Wielawski, 2004). In response to this initiative, SAMHSA's Center for Substance Abuse Prevention (CSAP) established its own effort, the *Community Partnership Program*, in 1990, giving approximately $375 million to fund 251 community partnerships across the country (Butterfoss, 2007).

In addition to these efforts, coalition building opportunities were initiated by several governmental and private agencies to address issues related to youth tobacco use. From 1993 to 1997, the National Cancer Institute (NCI) provided $128 million to fund the American Stop Smoking Intervention Study (ASSIST) (Butterfoss, 2007). ASSIST provided funding to help state and local health departments work with community coalitions in the planning and implementation of programs to reduce youth tobacco use (Butterfoss, 2007). Further, the Centers for Disease Control and Prevention (CDC) launched its Imperatives to Prevent and Control Tobacco Use (IMPACT) program to help fund states not involved in the ASSIST program (Butterfoss, 2007). Another effort was introduced by the RWJF in their *SmokeLess States* initiative to work with state and local community agencies in implementing and adopting strict tobacco control policies (Butterfoss, 2007).

More recently, the Drug Free Communities (DFC) program of the Office of National Drug Control Policy (ONDCP) was established as a result of the 1997 Drug Free Communities Act (Public Law 105-20). The DFC program supports the funding of community coalitions to tackle youth substance use issues, with goals of reducing youth substance use and increasing

community collaboration (ONDCP, 2014). DFC communities can receive awards of up to $125,000 per year for up to five years per award (ONDCP, 2014). Since its establishment, the DFC program has awarded nearly 2,000 grants to coalitions across all 50 states, reaching communities containing more than one third of the Nation's population (ONDCP, 2014). Today, the DFC program remains the top source of community substance abuse coalition funding nationally.

Early Evaluations

Since the expansion of community substance abuse coalitions, much research has been conducted to evaluate efforts and identify the coalition factors relevant to success. To date, these evaluations have produced mixed results. Although several evaluations have found positive associations, several coalition initiatives have failed to produce the desired community-level reductions in substance use (Hallfors et al., 2002; Yin et al., 1997). Yin and colleagues (1997) evaluated CSAP's *Community Partnership Program* that was discussed in the previous section. In this evaluation of 24 CSAP partnerships, only 8 partnerships produced any significant reductions for any of the 12 past-month and past-year substance abuse outcomes that were measured (Yin et al., 1997). The average partnership in this evaluation did not produce any prevention gains relative to the comparison communities (Yin et al., 1997). In another evaluation, Hallfors et al. (2002) examined the impacts of the 12 *Fighting Back* coalitions funded through the RWJF. This evaluation showed no effects regarding youth substance use and negative effects in communities in which adults were targeted (Hallfors et al., 2002). Researcher hypotheses for these coalition failures involved lack of coalition focus on EBPs, poor program

implementation, small targeted populations within the community, and/or low acceptance of coalition programs (Hallfors et al., 2002).

In addition to these single evaluations, early reviews on the impact of community coalitions were inconclusive (Kreuter et al., 2000; Roussos & Fawcett, 2000). Roussos and Fawcett (2000) reviewed 34 studies, examining the impact of 252 health-focused partnerships. Their review revealed that coalition actions can lead to environmental and behavior change, although the magnitude of these effects were not as great as intended (Roussos & Fawcett, 2000). Further, only 10 of the 34 studies reviewed reported improvements in distant population-level outcomes (Roussos & Fawcett, 2000). In another review, Kreuter et al. (2000) evaluated 68 articles to examine reasons why coalition strategies have produced limited evidence of their effectiveness. Three possible explanations were hypothesized, including: 1) coalitions are inefficient or insufficient for carrying out planning and implementation tasks, 2) expectations of health system change outcomes are unrealistic, and/or 3) health outcomes may occur, but go undetected because of difficulty in evaluating these efforts (Kreuter et al., 2000).

As demonstrated through these examples, simply gathering community stakeholders to tackle youth substance use issues is not enough to produce the desired community-level changes (Fagan et al., 2011). There are likely certain factors relevant to coalitions that can impact their effectiveness. Hallfors and colleagues (2002) made several recommendations for successful coalitions, including: 1) establishing clear, focused, and manageable goals, 2) choosing research-based programs, and 3) paying careful attention towards monitoring the implementation, dose, and quality of chosen programs. Coalition efforts have since built upon these lessons learned, with more recent examples of successful coalitions.

Coalition Successes

Although early evaluations of coalition efforts produced mixed results, there have been some success stories in recent coalition literature. In response to the issues highlighted in previous research, the Communities that Care (CTC) model has been developed to guide coalitions in the implementation of effective prevention strategies (Hawkins et al., 2002). Based on a prevention science framework, the CTC model works to reduce adolescent problem behaviors in a community through the high-quality implementation of EBPs by community coalitions to address identified community needs (Hawkins et al., 2002). One large randomized trial, the *Community Youth Development Study* (CYDS), evaluated the effects of the CTC model implemented within 12 small communities across 7 states (Hawkins et al., 2009). In this study, adolescents in communities following the CTC model reported reduced rates of past 30-day alcohol and tobacco use, past 2-week binge drinking, and delinquent behaviors within the previous year compared to those in control communities (Hawkins et al., 2009). In addition, CTC communities continued to report lower rates of adolescent initiation of alcohol use, tobacco use, and engagement in delinquent behaviors than control communities 8 years after the implementation of CTC and 3 years after funding for the study ended (Hawkins et al., 2014). Results of the CYDS also found that CTC coalitions were more likely to implement research-based programs with high rates of program fidelity than control communities (Arthur et al., 2010; Fagan et al., 2008a, 2008b, 2009).

Another coalition model that has demonstrated success in enhancing partnership use of EBPs and has shown reductions in community rates of youth substance use is PROmoting School-Community-University Partnerships to Enhance Resilience (PROSPER) (Spoth, Greenberg, Bierman, & Redmond, 2004). The PROSPER framework is specifically geared

towards the development of partnerships between community agencies, schools, and universities. The mission of the PROSPER partnerships is to enhance implementation of EBPs to build youth and family competence, with ongoing community needs assessment, implementation monitoring, and evaluation efforts (Spoth et al., 2004). A randomized study of the PROSPER model involving 28 communities revealed that PROSPER communities reported greater levels of youth and family protective factor outcomes than control communities (Redmond et al., 2009), as well as lower rates of adolescent use of a variety of substances (Spoth, Redmond, et al., 2007). PROSPER communities also maintained higher rates of implementation adherence to selected family-focused and school-based EBPs (Spoth, Guyll, Lillehoj, Redmond, & Greenberg, 2007), and resulted in increased partnership knowledge regarding the selection, implementation, and evaluation of EBPs than control communities (Crowley, Greenberg, Feinberg, Spoth, & Redmond, 2012).

Coalition Functioning

With the mixed research regarding coalition effectiveness, much research has been conducted to examine specific factors of organization and structure that promote coalition functioning and contribute to successful coalition outcomes. Coalition functioning has been measured in a variety of ways in the literature, defined broadly as those factors that promote successful implementation of coalition activities (Zakocs & Edwards, 2006). Measures of coalition functioning in the literature have included coalition member satisfaction, member participation, quality of a coalition's action plan, mobilization of resources, comprehensiveness of coalition activities, and extent to which the coalition action plan is implemented (Kegler, Steckler, Mcleroy, & Malek, 1998). Foster-Fishman and colleagues further identified coalition

member capacities, relational capacities, organizational capacities, and programmatic capacities that make up coalition functioning (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001). These capacities consist of the core skills and knowledge needed to effectively work collaboratively, build and implement effective programs, and build an effective coalition infrastructure (Foster-Fishman et al., 2001).

Research has identified a variety of factors from several domains that have been shown to influence coalition functioning and coalition ability to produce positive outcomes. Identified domains of influence include: coalition structural characteristics (e.g., coalition age, coalition size, level of formalization, representation of community sectors, lead agency type), characteristics of coalition members (e.g., attitudes, knowledge and skills, background, diversity), factors related to external and internal coalition relationships (e.g., quality of communication, level of conflict, member influence in decision-making, organizational climate), characteristics of leadership (e.g., strength, style, having paid coalition staff members), and population and community characteristics (e.g., size of region covered, level of community poverty, level community support) (Butterfoss, Goodman, & Wandersman, 1996; Butterfoss & Kegler, 2009; Foster-Fishman et al., 2001; Hays, Hays, DeVille, & Mulhall, 2000; Kegler et al., 1998; Lasker, Weiss, & Miller, 2001; Zakocs & Edwards, 2006; Zakocs & Guckenburg, 2007).

Some of these same influencing characteristics have also been suggested to be related to a coalition's choice to use evidence-based prevention plans and programs and their provision of implementation support (Brown, Feinberg, Shapiro, & Greenberg, 2013). Characteristics that have been shown to influence selection and implementation of evidence-based strategies include: those related to coalition structure (Brown, Feinberg, & Greenberg, 2010; Jasuja et al., 2005; Nargiso et al., 2013), the diversity of represented sectors (Jasuja et al., 2005), the ability to obtain

and mobilize resources (Brown et al., 2010; Jasuja et al., 2005; Nargiso et al., 2013), leadership strength and style (Brown et al., 2010; Nargiso et al., 2013), internal and external coalition relationships (Brown et al., 2010; Nargiso et al., 2013), coalition member knowledge and attitudes (Greenberg, Feinberg, Meyer-Chilenski, Spoth, & Redmond, 2007), availability of training and technical assistance (Feinberg, Ridenour, & Greenberg, 2008; Nargiso et al., 2013), characteristics of the region served (Jasuja et al., 2005), and levels of community poverty (Brown et al., 2010; Greenberg et al., 2007). All of these studies identified coalition factors in the context of specific EBP-promoting frameworks, such as CTC or PROSPER (Brown et al., 2010; Brown et al., 2013; Feinberg et al., 2008; Greenberg et al., 2007), or the general use of "best practices", such as the use of strategies to promote environmental change (Jasuja et al., 2005; Nargiso et al., 2013). No study to date has examined the relationship between coalition functioning and the implementation of EBPs within coalitions operating outside of specific prevention frameworks.

Conceptual Framework and Research Questions

The emergence and expansion of coalitions to address community health issues has outpaced the development of an all-encompassing coalition theory (Butterfoss & Kegler, 2009). Much research has been conducted to examine various features of coalition functioning, although the measures used across studies vary dramatically, with no universal agreement on the specific constructs that should be included. This is, in part, due to the fact that there is no single dominant theoretical framework for understanding community coalition functioning (Brown, Feinberg, & Greenberg, 2012). Recently, possible frameworks have been developed, although none have been extensively tested empirically. To further understand coalition functioning and make

advancements in the development of an empirically sound coalition theory, future coalition research should be guided by some sort of theoretical framework. For the current study, coalition functioning constructs are based on the critical elements outlined in Community Coalition Action Theory (Butterfoss & Kegler, 2009).

Community Coalition Action Theory. Community Coalition Action Theory (CCAT) was developed to help explain how community coalitions are developed, maintained, and how they function to produce community change outcomes (Butterfoss & Kegler, 2009). According to CCAT, coalitions progress through several stages, from formation, to institutionalization, to maintenance. As new community issues arise, coalitions continuously cycle through these various stages (Butterfoss & Kegler, 2009). Success at any stage, determining overall coalition functioning, depends on the presence of various identified constructs (Butterfoss & Kegler, 2009).

CCAT proposes a variety of different factors that affect a coalition's progression through the various stages and its ability to implement effective strategies to lead to community change and ultimately impact health or social outcomes. Coalition formation is first initiated by a lead community agency that brings together a variety of stakeholders, with various backgrounds, to address a perceived community health or social problem. As the coalition is developed, identified community leaders work to establish structures (e.g., rules and regulations, committees) and processes (e.g., enhanced communication, conflict management) to promote the coalition's effectiveness (Butterfoss & Kegler, 2009). These structures and processes work to ensure member engagement, a positive coalition climate, and the pooling of both internal and external resources (Butterfoss & Kegler, 2009). The coalition relies on these resources in

designing and/or identifying, adapting, and implementing effective strategies to meet their specific community needs (Butterfoss & Kegler, 2009). Overall, engaged coalition members, the availability of sufficient resources, and comprehensive, multi-level, and evidence-based planning and implementation leads to community change (Butterfoss & Kegler, 2009). In addition, factors relevant to the community's context will affect coalition progression throughout all stages of coalition development, including: if and how a coalition is formed, the stakeholders or community agencies that will make up the coalition, the health issue that the coalition will address, the types of strategies the coalition will use to address the identified problems, and how these strategies will be perceived by the community. `

CCAT was first published in 2002 (Butterfoss & Kegler, 2002). Although several studies have since used this theory in identifying coalition factors for evaluation (Brown et al., 2012; Butterfoss & Kegler, 2009), only one study has been conducted to test the appropriateness of this theory in explaining coalition functioning (Kegler & Swan, 2011). Kegler and Swan (2011) used data from an evaluation of 20 community coalitions to test the relationship between coalition factors and outcomes as predicted by the CCAT model. This first test of the CCAT framework yielded promising results, as many, but not all, of the CCAT relationships were supported (Kegler & Swan, 2011). However, not all of the CCAT constructs were included in this analysis and further research is still needed to replicate findings and advance the understanding of coalition functioning.

Study Purpose. Although research has demonstrated great variability in coalition organization and functioning, a common feature of successful coalition strategies has been the high-quality implementation of EBPs (Fagan et al., 2011). The examples in the literature

illustrate that when coalitions are organized around a prevention system that promotes the use of EBPs (e.g., CTC, PROSPER), successful adoption and high-quality implementation can occur. Less is known, however, about the factors that promote EBP adoption among coalitions operating outside of these frameworks. In addition, the vast differences in organization and functioning across coalitions make it unlikely that these prevention systems can be consistently and successfully implemented without adaptation. Even within these prevention frameworks, variation has been shown to exist in coalition adoption of EBPs (Shapiro et al., 2013), suggesting that there are other coalition features that influence their choice to implement an EBP. A need currently exists to understand differences in coalition functioning and how these differences may impact coalition use and implementation of EBPs.

Using the constructs shown in the CCAT framework to influence coalition functioning, the current study examined these differences. Taking a case study approach, the current project attempted to uncover differences in how community-based substance abuse coalitions function and provide preliminary insights into how these differences might influence coalition use and implementation of EBPs. The aims of the current study were to: 1) illustrate the similarities and differences in functioning across coalitions, 2) examine coalition perceptions, use, and implementation of EBPs, and 3) identify coalition factors associated with the perceptions, use, and implementation of EBPs. Emerging from the first two study aims, it was hypothesized that the coalitions identified would vary significantly across factors related to coalition functioning. Previous research has suggested that factors related to the size of the region covered by coalitions, the level of community sector involvement, and the age of the coalition itself are all related to differences in coalition functioning (Brown et al., 2010; Jasuja et al., 2005). Associated with the third study aim, the current researcher hypothesized that the identified factors that have

been shown to influence coalition functioning in the CCAT framework will also impact a coalition's use and implementation of EBPs. Findings based on these aims and hypotheses are meant to contribute to the understanding of coalition functioning and perceptions toward EBPs and will have implications for future community-based substance use prevention efforts.

CHAPTER THREE:

METHODS

To address the aims of the current study, a mixed methods design, including coalition member surveys and key leadership interviews was conducted. Secondary data was also used to describe each coalition's community context. The constructs that were measured and their associated relationship within the CCAT framework are illustrated in Figure 1. In addition, the data source(s) that was used to measure each construct is displayed in Table 1.

Participating Coalitions

Florida has been particularly active in the establishment of community-based substance abuse coalitions. As of 2014, the state of Florida had 28 established substance abuse coalitions that were receiving funding through the DFC program (ONDCP, 2014). These communities, however, vary extensively in their size and population served, likely contributing to differences across their associated coalitions regarding the level of community engagement, the types of prevention activities emphasized, and the overall coalition structure and organization. These variations make the coalitions of Florida a clear fit for the current research. For the current study, four local substance abuse coalitions within the SunCoast Region of Florida were selected to participate. In addition to their location, these coalitions were selected for several reasons. All four coalitions are current funding recipients of the DFC grant. This inclusion requirement ensures that the coalitions are well-established within their communities and that they organize

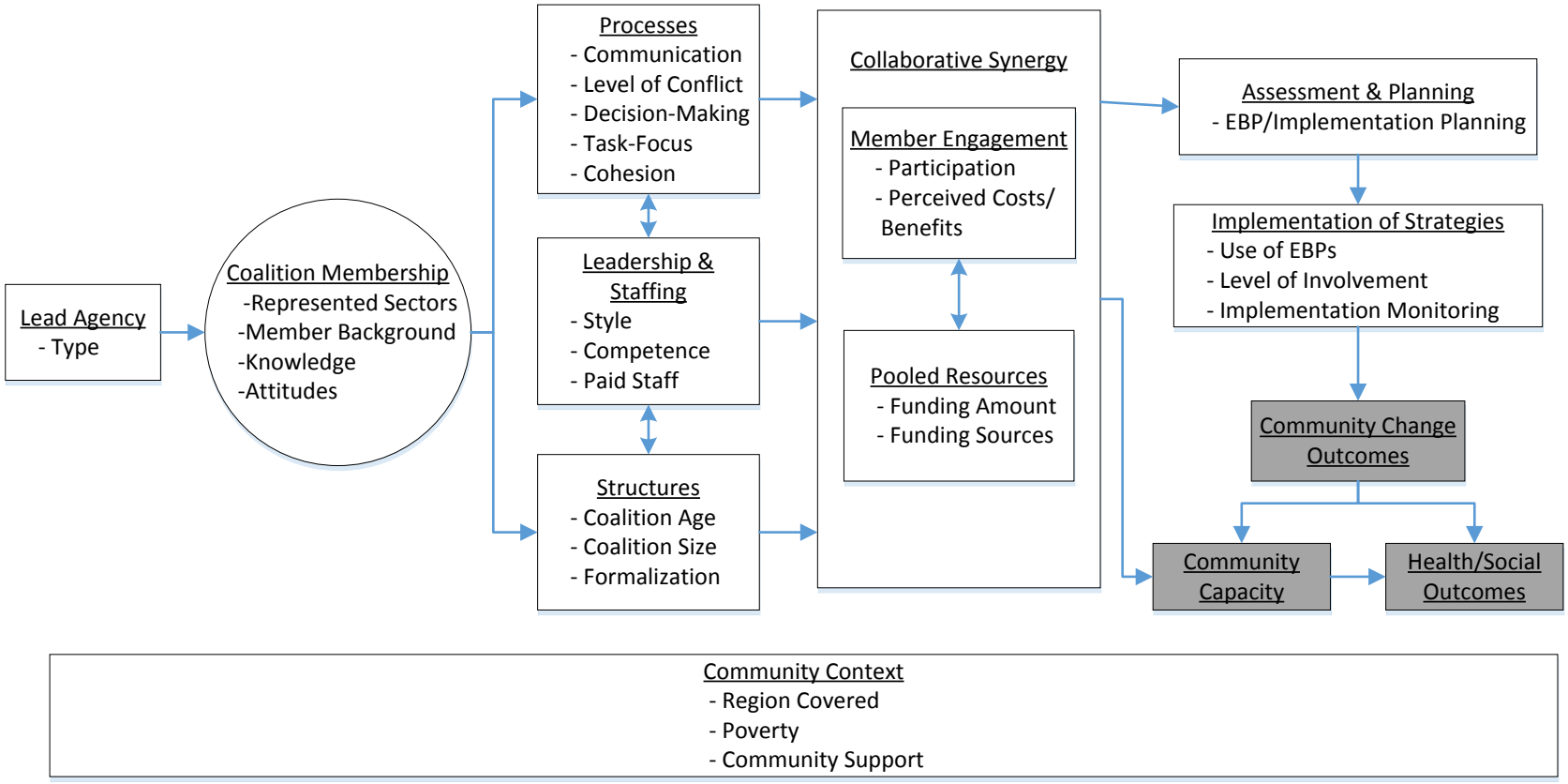

Figure 1. Measured Constructs and Relationship in the Community Coalition Action Theory Framework[1]

[1]Figure Adapted from Butterfoss & Kegler (2009)

Note: Shaded areas indicate CCAT constructs not measured in the study

their activities around issues related to youth substance use. Further, the DFC program outlines several types of strategies that coalitions should engage in, ensuring that the data collection tools can be consistently implemented across the coalitions to allow for better comparisons. Before the study began, the current researcher spoke with the leaders of each coalition to ensure their cooperation in the study. After the study was fully described to them, a letter of support was obtained for each coalition. Following the study's approval, the active members and key leaders from each of these four coalitions were invited to participate in questionnaires or interviews.

Coalition Member Questionnaire

To assess perceptions of coalition functioning and familiarity and attitude toward EBPs and implementation, surveys were distributed to active members of each coalition. The survey consisted of items crafted by the researcher and adaptations made from two previously published surveys. A full copy of the coalition member questionnaire can be found in Appendix A.

Coalition Functioning. To examine perceptions of coalition functioning, selected scales from the *Communities that Care Questionnaire* (Brown et al., 2012) were adapted and administered to coalition membership. The *Communities that Care Questionnaire* is one of the first attempts to develop an efficient and precise measure of coalition functioning (Brown et al., 2012). The measure was developed based on an extensive review of the literature and years of experience working with coalitions (Brown et al., 2012). Both exploratory and confirmatory factor analyses have been conducted in the past on this measure (Brown et al., 2012). Additionally, strong internal consistency, with Cronbach's α ranging from .84 to .92 across subscales, has been found in previous research using this measure (Brown et al., 2012). This 41

Table 1. Measured Constructs and Associated Data Source(s)

	Data Source		
Constructs	Interviews	Surveys	Secondary Data
Community Context			
Region Covered			x
Poverty			x
Community Support	x	x	
Lead Agency			
Type	x		
Coalition Membership			
Represented Sectors	x	x	
Prevention Knowledge	x	x	
Prevention Attitudes	x	x	
Coalition Processes			
Communication	x	x	
Level of Conflict	x	x	
Decision-Making	x	x	
Task-Focus	x	x	
Cohesion	x	x	
Leadership and Staffing			
Style	x	x	
Competence	x	x	
Paid staff	x		
Structures			
Coalition Age	x		
Coalition Size	x		
Formalization	x		
Member Engagement			
Participation	x	x	
Participation Costs/Benefits	x	x	
Pooled Resources			
Amount	x		
Sources	x		
EBP/Implementation Support			
EBP/Implementation Knowledge	x	x	
EBP/Implementation Attitudes	x	x	
Use of EBPs	x		
Level of Involvement	x		
Implementation Monitoring	x		
EBP/Implementation Planning	x		

item measure has not been copyrighted and was made available from the first author at no charge.

Because the measure was originally implemented among CTC coalitions receiving a specific funding source, several items had to be modified slightly or excluded entirely for the purposes of the current study. For example, all instances in which the questionnaire mentions CTC were edited to refer to the coalition, in general. Further, all mentions of the CTC mobilizer were edited to refer to the coalition leadership. Two questionnaire subscales, the *Board Membership* and *Sustainability Planning* subscales were excluded because they were specific to the CTC program and did not fit the context of the current study. For the current survey, eleven of the thirteen original subscales, representing five distinct domains, were maintained. The subscales and associated domains are described in detail below:

1. *Leadership.* The Leadership domain contained three subscales: *Board Leadership Style*, *Board Leadership Competence*, and *Mobilizer Skill*. The *Board Leadership Style* subscale contained three items directing respondents to describe their coalition's leadership, including their ability to consider other viewpoints, if they will assist members with specific tasks, and if they create an environment where differences of opinion can be voiced. The *Board Leadership Competence* subscale consisted of four items, inquiring about leadership's ability to mobilize resources, level of political knowledge, skill in conflict resolution, and respect in the community. All item responses on the first two leadership subscales were on a 7-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. The *Mobilizer Skill* subscale also contained four items, asking members to rate their leader's interpersonal and

communication skills, organizational skills, enthusiasm and passion, and prevention and coalition knowledge on a 7-point scale ranging from *Needs Work* to *Very Strong*.

2. *Task Focus.* The Task Focus domain contained two subscales: *Board Efficacy* and *Board Directedness.* The *Board Efficacy* subscale included three items directing respondents to describe their experience regarding coalition meetings over the previous year. The *Board Directedness* subscale consisted of four items. The first two items asked about leadership's vision for the coalition and their adoption of decision-making procedures. The final two items asked if the board has developed clear goals and has agreed how it will govern itself. All items within the Task Focus domain, except for the last two, were organized on a 7-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. The final two items were on a 7-point scale ranging from *No* to *Yes*.
3. *Interpersonal Relationships*. The Interpersonal Relationships domain included three subscales: *Cohesion, Conflict,* and *Leadership-Member communication*. Coalition cohesion was measured by five items which asked respondents to rate how much they agree or disagree with various statements about the coalition. Examples items in this subscale are *there is a strong feeling of belonging on this team* and *members of this team feel close to each other*. The *Conflict* subscale contained two items that asked respondents to report how much or how little tension and conflict they have noticed in their coalition over the previous year. *Leadership-Member communication* was measured with items asking participants to rate the frequency and productivity of communication between the coalition leadership and active membership.

4. *Community Interface.* Because the *Board Membership* subscale was excluded from the adapted survey, the Community Interface domain included only one subscale: *Community Support*. This subscale contained four items which asked respondents if their community's leadership understands the coalition, if the administration leadership of the community's school system supports the coalition, if the administration leadership in participating community agencies supports the coalition, and if the coalition board has relationships with other key community institutions. The item responses were on a 7-point scale ranging from *No* to *A Great Deal*.
5. *Participation Benefits and Costs.* The final domain includes the *Participation Benefits* and *Participation Difficulties* subscales, each including three items. For *Participation Benefits*, respondents were asked to indicate how much benefit they have gained from their involvement in the coalition in regards to learning new skills, developing valuable relationships, and feeling a sense of personal fulfillment. For *Participation Difficulties*, respondents were asked to indicate how much their involvement has interfered with their work schedule and responsibilities, their family life, and their personal free time. Both of these subscales were measured on a 7-point scale ranging from *Not at All* to *A Great Deal*.

Additional items were also adapted from the *Communities that Care Questionnaire* that did not correspond to any of the identified subscales. These items related to: coalition member background and experience, coalition involvement, and attitudes toward prevention programming. For prevention attitudes, two items were included. The first item assessed member attitude towards the effectiveness of school-based prevention programming and the second item related to member attitude toward prevention program investment. Both of these items were

modified from their original format in the *Communities that Care Questionnaire* and response options were also modified to be measured on a 7-point scale ranging from *Strongly Disagree* to *Strongly Agree*.

EBP Attitudes. To measure coalition members' attitudes towards the use of EBPs, several items were drafted by the researcher corresponding to general constructs outlined in Aarons' (2004) Evidence-Based Practice Attitude Scale (EBPAS). The EBPAS is a brief 15-item measure used in research and evaluation to assess behavioral health service provider attitudes towards the adoption and use of EBPs. The EBPAS is the only well-studied and validated measure to specifically examine mental health service provider attitudes toward the adoption of EBPs in community settings that has been published to date. The EBPAS was originally developed to cover four domains that have been shown in the research to influence the dissemination and implementation of EBPs. These domains include: intuitive appeal, organizational requirements, openness to innovation, and perceived divergence (Aarons, 2004). The EBPAS has been used in research and evaluation to examine overall provider attitudes toward EBP adoption and to identify the specific individual, organizational, and leadership characteristics associated with these attitudes (Aarons, 2004, 2006; Aarons et al., 2010; Aarons, Sommerfeld, & Walrath-Greene, 2009).

The current study adapted two of the four EBPAS subscales to examine member attitudes toward the adoption of EBPs by their coalition or by their coalition's partner agencies. Because the target population of coalition members differs from the population of mental health providers that the EBPAS was originally developed for, items had to be modified significantly. For this reason, the EBPAS may be thought of as the base in which items to examine attitudes towards

EBPs were developed. Specifically, the *Openness* and *Divergence* subscales of the EBPAS helped guide the development of specific items for the current study. The remaining two subscales, *Requirements* and *Appeal*, were excluded because of their limited relevance for coalition membership, which are often not the direct providers of EBPs. All items were measured on a five-point Likert scale ranging from *Not at All* to *To a Very Great Extent*. The subscales and specific items are described in greater detail below:

1. *Openness*. In the EBPAS, the *Openness* subscale contains four items that measure behavioral health service provider openness to new practices (Aarons, 2004). For the current study, these four items were modified significantly to refer to member support of the coalition's or partner agencies' use of new prevention programs, rather than their personal adoption of clinical therapies or interventions. The phrase *youth substance use* was also included in several of the items.
2. *Divergence*. In the EBPAS, the *Divergence* subscale consisted of four items corresponding to a perceived discrepancy between research-based interventions and professional practice or experience (Aarons, 2004). These items were modified significantly to refer to the reduction or prevention of youth substance use in their community, rather than to the care of their clients. Similarly, the phrases *clinical experience* and *therapy/interventions* were changed to *professional experience* and *prevention programs*. The wording of one additional item was reversed to avoid a potential double negative that could have occurred, depending on the participant's response.

Additional Survey Items. To measure the additional domains related to study aims that were not addressed by existing surveys, several items were developed by the current researcher. These items related to experience with prevention programs in general, experience with EBPs, and attitudes toward program implementation. For prevention program experience, respondents were asked to rate their level of familiarity with specific substance use prevention programs. Two additional items inquired about respondent familiarity with the term *evidence-based program* and with specific evidence-based substance use prevention programs. Response options for all experience items were on a 7-point scale ranging from *Strongly Disagree* to *Strongly Agree.* Additionally, two implementation items were included that assessed respondent attitudes towards the use of coalition resources for monitoring the implementation of prevention programs and towards the use of training and technical support for program implementation. Both of these items were on a 5-point scale ranging from *Not at All* to *To a Very Great Extent*.

Survey Finalization and Administration. After the coalition member survey was drafted, a copy was sent to individuals who have extensive experience working with coalitions for their feedback regarding the survey's readability and relevance. Based on their feedback, several survey items needed to be slightly revised before the survey instrument was finalized. The final measure was estimated to take between 15 and 20 minutes to complete.

Once the survey was finalized and the study was approved, the current researcher attended each coalition's monthly general meeting during June, 2014. At each of these meetings, the researcher spoke to the coalition membership about the project and answered any questions. After each of these meetings, paper-pencil copies of the survey were made available to interested members. After this, a link to an online version of the survey, created using Qualtrics ®

software, was emailed to coalition leadership who then disseminated the survey link via email to their coalition membership. Before the survey, an informed consent document was displayed to participants in both the paper-pencil and online survey versions. The survey was completely voluntary and no incentives were offered for participation. To encourage greater participation, one additional email reminder was sent by each of the coalition's leader(s) to their membership during June or July of 2014.

Key Leadership Interview

Semi-structured in-depth interviews were conducted with key coalition leadership to identify the presence of various factors related to coalition functioning and to examine their perceptions, use, and implementation of EBPs. A copy of the full interview protocol and pre-interview questionnaire can be found in Appendix B.

Interview Protocol. Before items were drafted for the interview protocol, a complete list of the relevant constructs, as identified by CCAT, was made. Possible interview items were then drafted to align with these constructs. In addition, several items intended to measure coalition leadership knowledge and use of EBPs were included. The specific constructs measured by the interview protocol are outlined in Table 1 and described more fully below.

Pre-interview questionnaire. After a rough draft of the interview protocol was initially developed, there was a concern regarding the length of the interview. To cut down on the time needed from interview participants, some of the background questions were removed from the interview protocol and were instead placed in a short one-page pre-interview questionnaire. The topics addressed by this questionnaire included: basic participant background information (e.g.,

length of involvement with the coalition, professional experience), perceived involvement of relevant community agency sectors as defined by the DFC program, and amount and types of funding sources received by the coalition.

Coalition functioning. In the interview protocol, items related to the coalition functioning constructs were based upon the same content domains measured through the coalition member surveys and outlined by CCAT. Respondents were first asked to describe their coalition's background (e.g., organization and structure, lead agency, major goals, leadership). Following these items, the protocol continued to cover content areas related to:

- Member engagement and participation (e.g., *How would you describe the overall level of member engagement in this coalition?*);
- Member relationships, communication, and overall cohesion (e.g., *How would you generally describe the relationships between coalition members? Do members generally get along well with each other?*);
- The coalition's decision-making process and focus (e.g., *What generally guides your coalition's decisions in prevention planning? Could you briefly describe the coalition's decision-making process?);*
- The larger community's perceptions of the coalition (e.g., *How would you describe the community's perceptions of this coalition? How do you gauge community support or the coalition and/or its activities?;* and
- Sophistication of prevention knowledge, associated attitudes, and the types of prevention activities emphasized (e.g., *How do you identify and prioritize substance abuse needs in your community? What seems to be the most important strategy(ies) to your coalition?*).

When asked about prevention strategies, a handout outlining the Seven Strategies for Community Change, as organized by CADCA (CADCA National Coalition Institute, 2009) and required as part of DFC funding, was provided to participants. Participants were asked to look over the strategies and identify the strategy or strategies that are most important to them or which they place the most emphasis. Throughout the protocol, several items and probes were also included to examine participants' leadership style and competence. For example, participants were asked to describe how they deal with conflict within the coalition, how they encourage membership participation, and what guides their decisions in prevention planning.

EBP knowledge and use. In the protocol, EBP knowledge was designed to be elicited by several questions used in previous research (Crowley et al., 2012), covering knowledge domains related to:

- Program sources (e.g., *…where would you go to research effective programs*?);
- Standards of evidence (e.g., *What kinds of information are important for you to decide if a prevention program is backed by good research?*);
- Fidelity assurance (e.g., *What's your approach to making sure prevention programs are implemented as they were designed?*); and
- Program evaluation (*What have you found to be the best ways to decide if a prevention program is working well in your community?*).

Additional items were crafted by the researcher to measure EBP familiarity and knowledge (e.g., *For the purposes of your coalition, how would you define what constitutes an evidence-based practice or program?*) and implementation knowledge and attitudes (e.g., *What do you think monitoring the implementation of prevention programs achieves?*). The use of EBPs, level of coalition involvement, and measures of implementation fidelity were also adapted from measures

employed in previous research (Brown et al., 2010). For these content areas, participants were asked to identify one or two prevention programs that the coalition has been involved with. Once the participant identified the prevention program(s), they were asked a series of questions related to their level of involvement in selection and implementation, any implementation monitoring, and any implementation training.

Interview Finalization and Procedures. Before the interview protocol was finalized, it was first sent to a content expert with experience working with the coalitions in the area for their feedback regarding interview comprehension. After a few minor edits, the interview protocol and pre-interview questionnaire were finalized. The final interview protocol and pre-interview questionnaire were estimated to take one hour to complete.

After each coalition agreed to participate in the research project through a letter of commitment and the study was approved by the Institutional Review Board, coalition leaders were approached at a regularly scheduled coalition meeting and informed about the interview. Following the meeting, leaders were contacted via email by the researcher and in-person interviews were scheduled based on their earliest convenience. All interviews except one were conducted over a period of two weeks. A final interview took place the following month due to initial scheduling conflicts. The majority of the interviews took place at the interviewee's office. Informed consent was verbally obtained from participants prior to each interview. Each participant took 3 to 5 minutes to complete the pre-interview questionnaire either directly before or after the interview. Several methods were taken to enhance the trustworthiness of the data obtained through the qualitative interviewing of coalition leaders, following criteria established by Guba (1981). With permission from the participants, all interviews were audio recorded with

additional notes taken by the researcher, enhancing the dependability and confirmability of the results.

Secondary Data

Finally, publically available secondary data were used to identify various community characteristics that have been shown to influence coalition functioning in the literature. Specifically, the 2010 U.S. Census data were used to describe the total population size for each of the communities (U.S. Census Bureau, 2010). Additionally, data from KIDS COUNT® were used to describe the total population size of children under 18 living and the number and proportion of children within each coalition's community living in poverty (The Annie E. Casey Foundation, 2014).

Data Analysis

All data pieces described above were used to produce a detailed description of each participating community substance abuse coalition. These descriptions were organized into four separate case descriptions, identifying similarities and differences in coalition functioning and use of EBPs. Additional analyses were conducted with the survey and interview data to further examine evidence-based practices across community substance abuse coalitions.

Surveys. All survey data were entered and analyzed using SPSS version 22.0 (IBM Corp., 2013). Prior to any analyses, several items had to be reverse-coded. These items included two coalition cohesion items, all three participation difficulty items, and three EBP attitude items that were negatively worded. Additional items were also recoded. The two length of coalition

involvement variables, referring separately to years and months, were combined into a single variable reflecting the total length of involvement in years. Additionally, two items inquiring about the number of hours given by member for coalition meetings and work outside of meetings were combined into one variable reflecting the total number of hours members devoted to coalition work in an average month. Further, the mean scores for the coalition functioning and EBP knowledge/attitude domains were computed. These domains included the eleven coalition functioning subscales and the two EBP attitude subscales defined in the previous Coalition Member Questionnaire section. Additional mean scores were computed for the substance abuse prevention attitude items, the EBP knowledge items, and the implementation attitude items. Because each of the sixteen domains consisted of four or fewer items, respondents with missing data for any of the separate domain items were excluded from mean score calculations. Across all sixteen domains, missing data averaged less than 9%.

Data were analyzed in several ways. Descriptive statistics were used largely in the production of separate case descriptions for each of the participating coalitions. In these descriptions, mean scores and standard deviations for the functioning and EBP/implementation domains were computed for each of the coalitions and for the total sample. Sample characteristics, including member role, member background, member involvement, and perceived influence, were also examined using descriptive statistics for the separate coalitions.

An exploratory factor analysis (EFA) was also conducted to examine the underlying structure of the EBP attitude measure, consisting of eight items described earlier. A range of recommendations regarding the appropriate sample size needed to obtain stable EFA results has been found in the literature (MacCallum, Widaman, Preacher, & Hong, 2001) and although a sample size of 100 or larger is preferred for this type of analysis, the sample size for the current

study (N = 82) did meet the commonly accepted ten-to-one ratio of observations to variables (Hair, Tatham, Anderson, & Black, 2006). Further, to assess the factorability of the data, the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) value and Bartlett's test of sphericity were examined. The KMO value was above .6 and Bartlett's test of sphericity, which tests the hypothesis that factor correlations are zero, was significant. Both of these indicators suggest that factor analysis was appropriate (Tabachnick & Fidell, 2007).

Factors were extracted using Principle Axis Factoring. Promax oblique rotation was used, as it was expected that EBP attitude subscales would be related (Tabachnick & Fidell, 2007). Factors were retained based on the Kaiser criteria, using eigenvalues greater than one (Kaiser, 1960). The scree plot was also examined to evaluate the appropriateness of the retained factors. To promote simple structure, items were retained on a factor if they loaded at least .32 on the primary factor (Tabachnick & Fidell, 2007). Following the EFA, reliability analyses, using Cronbach's alphas, were conducted to examine the internal consistency of identified subscales.

To examine similarities and differences in coalition functioning and EBP across the coalitions, one-way analysis of variance (ANOVA) tests were conducted. The coalition served as the independent (grouping) variable in each ANOVA and the seventeen coalition functioning and EBP subscales described earlier served as the dependent variables in these analyses. Finally, to examine potential bivariate associations between coalition characteristics and attitudes toward EBP, Pearson's product-moment correlations were conducted. The independent variables used in the bivariate analyses included fourteen mean subscale scores related to: leadership style, leadership competence, leadership skill, board efficacy, board directedness, cohesion, conflict, leadership-member communication, community support, participation benefits, participation difficulties, prevention attitude, EBP knowledge, and implementation attitude. The dependent

variable used was the overall EBP attitude score, computed by taking the mean score of the eight EBP attitude items. Only participants who responded to at least six of the eight EBP attitude items were included in the bivariate analyses, excluding five respondents with missing data exceeding this requirement. A small sample size prohibited the inclusion of an additional multiple regression analysis to identify specific coalition functioning factors associated with coalition member attitudes toward EBP (Tabachnick & Fidell, 2007).

Interviews. A thematic analysis was conducted with the interview data for an in-depth examination of coalition functioning and use of EBPs. Three levels of data were identified in this thematic analysis, including articulated, attributional, and emergent data, outlined by Massey (2011). Articulated data refer to the responses offered by participants to directly address the specific questions or probes presented by the researcher (Massey, 2011). In the current study, this type of data was used to understand how coalition leadership interpret the various domains related to coalition functioning and use of EBPs, how they rate their coalition across the various domains, and where they place the greatest emphasis. Attributional data were also examined to test a series of if-then hypotheses. According to Miles and Huberman (1994), if-then hypothesis tests can be thought of as the "workhorse of qualitative data analysis" (pg. 271), serving as a more focused way to organize inquiry and facilitate decision-making. A summary of the hypotheses used for the current interview data are illustrated in Table 2.

Consider, for instance, the interview item intended to examine leadership's knowledge of and attitude towards monitoring the implementation of selected programs. Articulated data would refer to the interviewee's actual response to the item. If the respondent indicates that they believe implementation monitoring is important, but does not go into detail as to why, that

response should not be ignored and it is important to note that the respondent did verbally indicate a positive attitude towards implementation. Additional information, however, can be obtained by considering the attributional data. For example, one of the hypotheses that was tested related to the sophistication of responses elicited by the item above. One can hypothesize that if coalition leadership is truly committed to the high-quality implementation of programs, then they will be able to identify specific examples as to why they believe implementation monitoring is important. Finally, interviews were analyzed to identify the presence of any emergent themes that were not initially hypothesized.

In the analysis, themes or "codes" were identified both inductively and deductively (Bernard & Ryan, 2010). Using the original content domains which guided the development of the initial interview protocol, a provisional codebook was developed to assist in the organization and analysis of the interview data. Following the codebook's development, the current researcher and an independent user separately coded one interview transcript using the definitions outlined in the codebook. After the initial coding, the two coders came together to compare their coding and discuss their coding agreement, any superfluous codes, and the need for new codes. The codebook was amended as a result of this discussion and the interviews were coded using the modified codebook. As the coding process progressed further, additional themes emerged and new associated codes were created. The finalized codebook consisted of topic domains, primary codes, definitions, and inclusion and exclusion criteria. All interviews were coded based on the criteria specified in the codebook. Interview coding and analysis was facilitated by the use of ATLAS.ti version 6.2 software (Scientific Software Development, 2010). Additionally, the responses to the pre-interview questionnaire were used in the development of the case descriptions for each of the coalitions.

Table 2. If-Then Hypothesis Testing for Key Leader Interviews

Domain	If –	Then –
Communication	There is frequent and productive communication between coalition members and among leadership.	Interviewees will identify several specific modes of communication.
Cohesion	The whole coalition is committed to the coalition's vision	Responses will include specific examples of positive member relationships, closeness, and group spirit.
Conflict	Tension and/or conflict is present within the coalition.	Responses will include specific examples of conflict within their coalition.
Task Focus	The coalition board has adopted a clear vision and has developed clear objectives, and decision-making procedures.	Interviewees from the same coalition will agree on the coalition's vision, goals, and decision-making process. Specific goals and objectives that fit an overall articulated coalition vision will be included. Clear decision-making procedures will be discussed.
Community Support	The community recognizes and supports the coalition's activities	Responses will include specific examples of how the community has supported coalition activities.
Leadership Style	The director/chair/coordinator demonstrates an empowering leadership style within their coalition.	Responses to interview items will include specific examples about: turning to the coalition for input in decision-making, respecting the viewpoints of others, and recognizing coalition member work.
Leadership Competence	The director/chair/coordinator serves as an effective leader within their coalition.	Their responses will be focused and clear; they will identify the key "players" in their community; they will be able to identify a specific strategy for dealing with conflict within their coalition.
EBP	The director/chair/coordinator is familiar with EBP.	They will discuss specific evidence-based programs/practices and their definitions will be more sophisticated.
Implementation	The director/chair/coordinator understands and emphasizes quality implementation.	Their discussion on these topics will be more sophisticated and they will be able to provide specific examples.

Ethical Considerations

The current study was considered low or minimal risk to participants. Prior to any data collection, the leaders of each of the coalitions signed a letter of support and the study protocol was approved by the Institutional Review Board of the University of South Florida. A copy of the IRB approval letter can be found in Appendix C.

CHAPTER FOUR:

RESULTS

Survey Participants

A total of 82 individuals completed the coalition member questionnaire. Thirty four of these responses were completed using the paper-pencil version of the survey, while the remaining 48 were completed online. Respondents represented a variety of occupational sectors within their community. As demonstrated in Figure 2, the education sector was the most commonly represented sector in the sample (21%), followed closely by health services (18%) and public human services (17%). The least represented community sectors included the faith community (1%), the judicial system (5%), and law enforcement (5%).

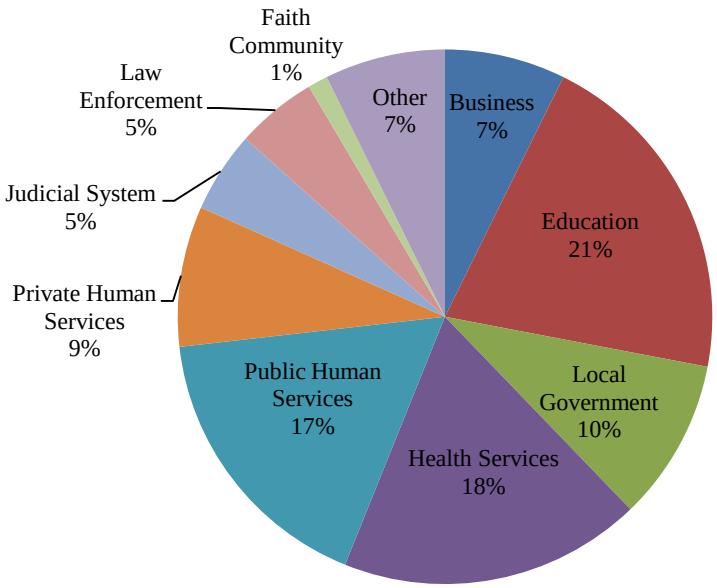

Figure 2. Community Sectors Represented in the Survey Sample

The majority of respondents (74%) reported that their community agency was involved in the implementation of youth-focused prevention programs. The roles of respondents within their coalition also varied, with 45% of participants reporting their status as a regular coalition member, 26% reporting coalition board membership, and 21% reporting a role as a coalition staff member. Respondents reported an average of 1.5 years of experience working with their coalition. The exact response rate for the surveys cannot be determined, as the online version of the survey was disseminated by coalition leaders via coalition listservs that are likely to include some outdated email information.

Interview Participants

Both the director or coordinator and chairperson participated in an interview for each of the four coalitions, resulting in a total sample size of eight key coalition leaders. The resulting interviews lasted anywhere between 45 and 75 minutes. All participants were female and had varying experience both working within their coalition (ranging from 3 to 13 years) and maintaining their leadership position (ranging from 6 months to 5 years). Three of the eight participants came from a behavioral health background, three came from a background working with other coalitions, one participant came from a background in health services, and a final participant came from a law enforcement background. Six of the participants reported having a Master's degree, one a Bachelor's degree, and one a M.D., J.D., or other professional degree.

Exploratory Factor Analysis

The EFA for the eight EBP attitude items produced a two-factor solution, as determined by examining the scree plot and associated eigenvalues. The solution retained all eight items and

accounted for over 48% of the total variance. Table 3 shows the percentage of variance explained, eigenvalues, internal consistency reliabilities, and item loading for both of the identified factors. The original measure was loosely developed based on the *Openness* and *Divergence* subscales of Aaron's 2004 EBPAS. The resulting factors produced through the current EFA were generally consistent with the original subscales of the EBPAS. The first identified factor consisted of positively worded items intended to look at member openness to coalition use of new programs, corresponding to the EBPAS's *Openness* subscale. The second factor, on the other hand, consisted of items intended to assess a divergence between EBP and professional experience or current practice. One item, number 4 in Table 3, which was based on one of the original EBPAS *Divergence* items, loaded with the *Openness* subscale in the current EFA. However, the tone and phrasing of this item was modified significantly for the purposes of the current study. With these modifications, this item did conceptually relate to the other items loading on this factor. One of the items, number 5 in Table 3, was determined to be factorally complex, loading highly (>.40) on both factors. However, the item was retained on factor one as it had a greater factor loading (.54) and was conceptually related to the other items on this factor. The measure produced an overall scale Cronbach's alpha of .68 with subscale alphas of .78 and .71. The overall scale alpha value is lower than .70, which has been used in the past as an indicator of a "good" scale (Streiner & Norman, 2008). However, subscale alphas met this criterion. In addition, the second factor, based on the EBPAS *Divergence* subscale, exceeded the levels of internal consistency reliability obtained in previous studies using this measure (Aarons, 2004; Aarons et al., 2010).

Table 3. EFA Loadings, % of Variance, Eigenvalues, and Cronbach's Alphas for EBP Attitude Measure (N = 82)*

Measure Items	% of Variance	EV	α	Factor 1	Factor 2
1. Openness	27.95	2.24	.78		
1. I would support coalition or partner use of new types of programs, even if they have to follow a manual.				.77	
2. I would like my coalition or partners to use new programs to reduce youth substance use.				.75	- .33
3. I would support coalition or partner use of new and different types of programs developed by researchers to reduce youth substance use.				.62	
4. Services and interventions developed by researchers can benefit this community.				.54	.44
5. I would support coalition or partner use of a new program to reduce youth substance use even if it were very different from what I am used to doing.				.46	.35
2. Divergence	20.36	1.63	.71		
6. I know better than academic researchers how to address youth substance use in my community.					.81
7. Professional experience is more important than research when it comes to youth substance use prevention.					.67
8. I would not support coalition or partner use of manualized prevention programs.					.40
Measure Total	48.31		.68		

*EV = eigenvalue; α = Cronbach's alpha; factor loadings <.32 are not shown.

Coalition Case Descriptions

Using information from the secondary data, coalition member surveys and key leader interviews, a description of each of the four participating community substance abuse coalitions was developed. These descriptions detail information related to the specific context of each of the communities and the organization, functioning, and perceptions and use of EBPs of the corresponding community coalition. These case descriptions can be found in the following section. Tables 4 and 5 detail some of these comparisons, including general community and coalition characteristics (Table 4) and mean survey scores for the measured constructs (Table 5) organized by coalition. More detailed information about overall coalition knowledge and use of EBPs and implementation are discussed later in Chapter four.

Table 4. Coalition Background Information

	Coalition			
	A	**B**	**C**	**D**
County Background				
Population[1]	1,229,226	322,833	464,697	916,542
% under 18[2]	23.8	20.3	21	17.5
% of children living in poverty[2]	26.8	24.5	18.7	21.4
Coalition Background				
Year established	1989	2001	2006	2003
# of task forces/workgroups*	4	5	6	5
# of paid staff	8	4	2	4
Original Lead agency	Criminal Justice Department	Children's Services	Behavioral health agency	Department of Juvenile Justice
Current Lead Agency	Independent 501(c)(3)	Independent 501(c)(3)	Operates within behavioral health agency	Operates within behavioral health agency
# of community sectors surveyed	8	7	9	9
Mean sector involvement ratings	2.83	3.25	3.29	3.59
Estimated total funding (past year)	$475,000	$275,000	$200,000	$458,000
Estimated # of funding sources	5	4	3	3
Leadership				
Average # of years with coalition	8.13	6.58	6.33	5.00
Average # of years in current leadership position	1.88	5.00	4.83	1.00

Sources: [1]U.S. Census Bureau (2010); [2]The Annie E. Casey Foundation, KIDS COUNT® Data Center (2014).
*Coalition Board committees are not included in this number.

Coalition A. The first coalition included in the current study serves one of the largest counties in Florida, with a population of over 1.2 million. Out of the four counties included in the present study, the county of Coalition A ranks at the top for the percentage of the population under the age of 18 years-old (23.8%; 299,189 children) and the percentage of children living in poverty (26.8%) (The Annie E. Casey Foundation, 2014). Coalition A was the oldest coalition included in the present study. According to the interviews conducted with Coalition A's leadership, the coalition was originally formed through the Criminal Justice Department in 1989 as an advisory committee to the board of county commissioners to address issues related to substance use. As the organization grew, it turned into a community coalition and obtained status

as a 501(c)(3) nonprofit organization in 2003. Shortly after this change in status, the coalition was awarded its first Drug Free Communities (DFC) grant. According to interviewees, Coalition A maintains approximately 189 active members, with representatives from all 12 community sectors outlined by the DFC program and has received approximately $475,000 in funding, from an estimated 5 sources over the previous year. Coalition A defines *active membership* as regular attendance and/or participation in coalition activities. These activities can include attendance at the coalition general, Board, task force or youth group meetings and/or events. The overall goal of coalition A, as articulated by both interviewees, is to reduce substance use among youth within their county. Coalition A focuses on prevention strategies that specifically target underage alcohol use, tobacco use, marijuana use, and prescription drug abuse.

As a 501(c)(3), Coalition A has an established Board of Directors. The Board oversees all business aspects of the coalition and has hired an executive director, who is in charge of overseeing the coalition's finances and making sure coalition strategies are being implemented. The executive director of coalition A also oversees seven coalition staff members in charge of different activities within the coalition. As alluded to above, Coalition A contains four task forces, each in charge of addressing a specific substance of concern within the county. Specifically, the coalition consists of a separate tobacco, alcohol, prescription drug, and marijuana taskforce. According to interviewees, the tobacco task force, although housed within the coalition, operates somewhat independently from other coalition activities. The tobacco task force has its own separate funding sources and maintains three employees. Most of the remaining funding sources are used in the alcohol task force to specifically prevent underage drinking and driving under the influence. The remaining two task forces, prescription drugs and marijuana, work mostly with volunteers and community efforts.

Formalization. One area of interest in the current study was the level of coalition formalization, examined through descriptions of the coalition's structure, policies, and meetings. As discussed briefly above, Coalition A has established a Board of Directors, which acts as a governing body for the coalition, in charge of developing coalition policies, goals, and their strategic plan. In times of need, ad hoc committees can be formed under the coalition's Board to address topics related to the governance of the coalition, such as fundraising. In addition to the Board, Coalition A also has the four taskforces described earlier, organized under the coalition's general membership. Even further, two separate youth groups have formed under these taskforces. In the interview, the executive director of Coalition A described their organization as follows: "*we have the overall Board, they hire me to oversee staff, and then we work with the general membership to get the strategies done in the community."*

When asked about coalition meetings, both interviewees from Coalition A provided similar descriptions. Interviewees described two basic types of coalition meetings that occur: the general coalition meeting and the individual task force meetings. The general coalition meeting occurs every two months and serves to update coalition members on the work completed by each of the task forces. The meeting is run by the coalition chair and starts with an agenda and a review of the previous meeting's minutes and is generally followed by a presentation on a topic of relevance to the coalition. Following the presentation, each of the coalition's task forces gives an update on their activities during the previous two months and provides information on any upcoming events. The task force meetings, which occur monthly for each task force, are "*where the work gets done"* and are described as less structured meetings in which partners discuss community needs, identify and select potential strategies, and plan and implement identified strategies.

Task focus. Coalition task focus was assessed through both the surveys and interviews. As demonstrated in Table 5, the members of Coalition A rated the efficiency and directedness of their coalition Board highly. Levels of task focus can also be inferred from interview responses. If the coalition board has adopted a clear vision, objectives, and decision-making procedures, then it can be expected that interviewees within the same coalition will demonstrate agreement on these matters and identify specifics in their discussions. This was present to some degree in the interviews. Both interviewees clearly stated that the coalition's overall vision was to reduce substance use among youth across their county. They also agreed, as outlined through their task forces, that they specifically hope to address youth substance abuse issues related to tobacco, alcohol, prescription drugs, and marijuana use.

When asked to describe their coalition's decision-making procedures, interviewees discussed the development of gap analyses and coalition action plans. Depending on the issue topic (e.g., coalition business, specific substance, emerging issue) the coalition board, the associated task force, or the coalition's general membership will be involved in conducting a needs assessment and/or gap analysis and outlining an associated action plan. The chair of Coalition A described their decision-making process in reference to identifying strategies and priorities to incorporate into a funding proposal as the following:

> *We had meetings. So we sat down at the [taskforce] meeting. We had some forms that asked people what strategies were needed around here. What are the biggest issues? What are the strategies for that? Which ones do we have in place and what are the gaps we need to fill? So we would sit down with law enforcement and go over with them, with the schools and go over with them, what do we need, where are the gaps, and what do we*

need? That's what we would write into the grant, and that is the funding that we asked for, so basically that's how you do it. Do a gaps analysis.

Table 5. Coalition Member Questionnaire Results by Coalition*

	Coalition				
	A (*n* = 24)	**B** (*n* = 14)	**C** (*n* = 22)	**D** (*n* = 18)	**Significance**
Domain/Construct	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*F* (*df*), *p*
Leadership					
Style	6.19 (1.08)	6.06 (1.39)	6.10 (1.22)	5.84 (0.97)	0.27 (3, 67), 0.84
Competence	6.21 (0.77)	5.90 (1.50)	6.10 (1.33)	6.27 (0.56)	0.29 (3, 64), 0.83
Skill	6.48 (1.02)	6.05 (1.49)	6.19(1.26)	5.63 (1.20)	1.58 (3, 72), 0.20
Community Interface					
Community support	5.25 (1.13)	4.81 (1.23)	5.54 (0.90)	5.60 (1.13)	1.46 (3, 61), 0.23
Task Focus					
Efficiency	6.18 (1.02)	5.60 (1.52)	5.70 (1.82)	5.76 (1.13)	0.71 (3, 73), 0.55
Directedness	6.29 (0.77)	6.50 (0.77)	6.14 (0.82)	6.46 (0.69)	0.75 (3, 64), 0.53
Interpersonal Relationships					
Cohesion	6.23 (1.14)	5.65 (1.60)	5.90 (0.76)	5.55 (1.52)	1.16 (3, 68), 0.33
Conflict**	5.89 (1.53)	4.75 (1.92)	5.74 (1.18)	5.67 (1.58)	1.60 (3, 67), 0.20
Communication	5.54 (0.71)	5.61 (0.76)	5.41 (1.23)	5.22 (1.26)	0.48 (3, 73), 0.70
Participation Benefits and Costs					
Participation benefits	5.81(1.45)	5.92 (1.66)	6.09 (1.15)	6.16 (1.02)	0.24 (3 65), 0.87
Participation difficulties**	6.46 (0.77)	5.85 (1.16)	6.03 (1.25)	5.73 (1.20)	1.59 (3, 66), 0.20
Prevention and EBP					
Prevention experience/attitude	6.65 (0.55)	6.15 (1.08)	6.68 (0.37)	6.67 (0.47)	2.40 (3, 67), 0.08
EBP knowledge/experience	6.70 (0.57)	6.38 (0.87)	6.35 (1.14)	6.41 (1.02)	0.66 (3, 67), 0.58
Implementation attitude	3.98 (0.81)	3.73 (0.86)	4.00 (0.78)	4.17 (0.67)	0.72 (3, 68), 0.54
EBP attitude (total)	3.90 (0.71)	3.82 (0.35)	3.72 (0.39)	3.86 (0.39)	0.47 (3, 69), 0.71
Openness	3.92 (0.86)	3.54 (0.80)	3.61 (0.55)	3.72 (0.56)	1.02 (3, 68), 0.39
Divergence**	3.91 (1.08)	4.08 (0.88)	3.78 (0.76)	4.07 (0.97)	0.38 (3, 66), 0.77

* There is some variation in *n* across variables due to missing data.
**Indicates constructs that were reverse-scored.

Coalition membership. A total of 24 individuals from coalition A completed the membership survey. Survey respondents came from eight of the ten surveyed sectors, with no representation from the business or faith communities. Survey respondents from Coalition A

indicated a mean of nearly six years of experience with the coalition. In addition, 67% of survey respondents indicated attending more than 50% of the coalition meetings within the previous year, 100% of respondents indicated talking at a meeting over the previous year, and 59% reported serving as a member on a coalition subcommittee in the previous year. When asked to rate the overall level of engagement of coalition members across the twelve community sectors identified by DFC, coalition leaders agreed upon high involvement from youth-serving organizations and law enforcement, followed by parents and schools. The media and religious organizations were rated as having the lowest levels of involvement in Coalition A activities.

Several statements about coalition membership and levels of engagement can be drawn from the key leadership interviews. Both interviewees indicated differing levels of engagement across the coalition members, both emphasizing participation in a coalition task force as an indicator of higher involvement. One leader from Coalition A made the following statement describing member engagement:

> *Our volunteers run our meetings…Our board chair is [name], she is a volunteer. She is not staff. She does that on her own time. All of those members are volunteers that govern, oversee the whole organization. Each of the task forces is chaired by a volunteer. So they provide direction, they run the meetings, they help guide the activities of that and we support that.*

Interpersonal relationships. Both the coalition member surveys and leadership interviews can be used to describe the interpersonal relationships within Coalition A. As shown in Table 4, survey respondents reported high levels of communication and cohesion and low levels of conflict within Coalition A. In the interviews, coalition leaders were able to describe multiple occurrences of communication that occur between coalition members, including:

networking at meetings, frequent newsletters and email information blasts, other email correspondence, and carpooling to coalition events. Several statements were also made to suggest some level of cohesion within the coalition. Examples of these statements include: *"There is an intersection between what they do and what we do, so we can work together on things"*; *"we all know each other…and they have all known each other for years"*; and "*it's also about relationships. It is all about…to be successful and to sustain it over time, it is all about long-term relationships in the community*." Although several statements were made to suggest strong levels of cohesion within Coalition A, several examples of conflicts that have occurred were also discussed. Both coalition leaders discussed a major conflict that occurred several years earlier that resulted in negative media coverage and withdrawal of several coalition board members. However, both leaders agreed that the coalition was able to move past the conflict, citing the strength of their board and the hard work of several coalition members. They both agreed that currently, conflict or tension was not an issue within the coalition.

Participation benefits and costs. Through their participation in the coalition, members reported gaining between some and a great deal of benefit related to the development of new skills, valuable relationships, and a feeling a sense of personal fulfillment. Members also reported little interference to their work schedule, family life, and personal free time in relation to their involvement in their coalition. Leaders emphasized the coalition's goal of capacity building throughout their interviews and did not identify any costs related to member participation.

Community Support. Out of all of the functioning domains measured in the coalition member surveys, community support was rated the lowest for Coalition A. However, the rated level of community support for Coalition A was still similar to that of the other participating

coalitions. Coalition leaders identified both strengths and challenges related to community support in the interviews. Both leaders were able to provide specific examples of how community leaders have supported coalition activities in the past, including: providing a space for coalition meetings or events, public recognitions of coalition activities, collaborating on funding projects or with community events, including the coalition in a community resource book, and looking to the coalition as a resource in the community. Challenges identified by leadership regarding community support included the lack of awareness in the general community and the large size of the community being served. However, both leaders agreed that they believe influential community leaders support the coalition. Both interviewees also emphasized the strong support law enforcement has had regarding coalition activities. Across both interviews, law enforcement was acknowledged seven separate times in relation to their support of the coalition.

Leadership. Both leadership style and competence were examined in the surveys and interviews. Members rated their leadership's competence, skill, and overall style highly. In addition, when asked about their perceived level of influence, 48% of coalition members reported that they felt they had *A Lot of Influence* or *A Great Deal of Influence* in coalition decision-making. Leaders also demonstrated an empowering leadership style through their interviews. Interviewees spoke of the importance of including coalition membership in decision-making, welcoming input from different points of view, and turning to their coalition partners for their expertise. One interviewee summed up her experience with the quote: "*We all help each other, that's what coalitions do*." The competence of coalition leaders was also demonstrated through the interviews. Leaders were able to identify many of the key "players" in their community, demonstrated a high level of knowledge regarding issues in their community and

within their coalition, were familiar with a wide array of prevention strategies and the current research in the field, demonstrated an openness for developing new skills, were familiar with available funding sources, and had experience in grant writing.

Prevention activities. Members of Coalition A had positive attitudes regarding the use of prevention programs, with all survey respondents indicating agreement that school-based prevention programs can work and that substance abuse prevention programs are a good investment. Most members also indicated that they had some familiarity with specific prevention programs, were familiar with the term *evidence-based program*, and held some knowledge about specific EBPs. Coalition leaders identified a variety of strategies and activities that their coalition has used in the past, including social marketing strategies, education and community presentations, providing prevention training, supporting coalition partner events, and changing local policy. They were also familiar with seven community change strategies outlined by CADCA (CADCA National Coalition Institute, 2009). Although leaders indicated that the coalition does not implement evidence-based programs, they were familiar with the term and did discuss ways in which they support their partners in this endeavor.

Coalition B. The second coalition is situated in a Florida county containing just over 322,000 residents (U.S. Census Bureau, 2010), representing the smallest county included in the present study. Just over 20% (67,086 individuals) of the county's population is under the age of 18 years-old, with a child poverty rate of 24.5% (The Annie E. Casey Foundation, 2014). According to the interviews with leadership, Coalition B formed as a result of a community assessment in 2001, led by the county's Department of Children's Services with support from county law enforcement, school officials, and healthcare professionals. In 2008, the coalition

received its first DFC grant, which helped them reorganize themselves, hire an executive director, and focus their prevention activities. It was during this time that the coalition also applied for and obtained status as a 501(c)(3) nonprofit organization. According to leadership, Coalition B currently maintains nearly 300 active members, with representation from all 12 community sectors outlined by the DFC program, three full time staff members, and one part time staff member and has received approximately $275,000 from four funding sources over the previous year. The coalition defined active membership in this particular instance as those individuals who receive regular updates or notices regarding coalition meetings, surveys, and events. The coalition's major goals, as identified by their leadership, are based on specific substances of abuse. Specifically, Coalition B has developed strategies to address alcohol use, prescription drug abuse, and marijuana use. One leader identified an additional overall coalition goal of supporting health and wellness within their county across the lifespan.

Coalition B has an established Board of Directors, recruited throughout the community, who develop and oversee coalition policy, finances, and all coalition initiatives and action plans. Several committees have also been formed under the board related to assessment and evaluation, planning and implementation, and sustainability and capacity. An executive director is hired underneath the coalition's Board who is in charge of coalition staff members. Within the coalition, leadership discussed the formation of several task forces, including an alcohol task force, prescription drug task force, and a marijuana task force. Both leaders also spoke of a coalition youth commission and a task force focused on veteran's issues.

Formalization. As discussed in the section above, Coalition B has a formal governing body through their Board of Directors. The coalition itself is also divided into several committees and task forces, to further organize and support strategies. Coalition leaders

discussed several formal policies and procedures that take place within the coalition, including specific examples of policy development within the coalition. Decision-making procedures include voting and consensus reaching with final Board approval.

Coalition B discussed three general types of coalition meetings: the general coalition meeting, the separate task force meetings, and the board/committee meetings. The general meetings occur monthly and were described as: "*open"*, "*informal"*, and "*laid back"*. According to leaders, general meetings start out with introductions, followed by a review of meeting minutes, task force reports and updates, and an open discussion in which members participate in a "*group think"* around a specific topic or emerging community trend. Speakers are also identified to present at general meetings. The task force meetings are smaller. These meetings also occur monthly, have their own agendas, and are where much of the coalition's planning takes place. The Board committee meetings are much smaller (as few as three people) and do not occur on a regular basis. These meetings involve planning for all board-related activities (e.g., strategy evaluation).

Task focus. As shown in Table 5, coalition members rated the efficiency and directedness of their coalition board highly. In fact, out of all the coalition functioning domains measured for Coalition B, the Board directedness domain was rated the highest. In the interviews, both leaders agreed on coalition goals related to the specific substances targeted by their task forces. They also spoke about the importance of identifying specific functions for the coalition, crafting strategies to align with a universal goal, and basing decisions on the coalition's mission. One leader from Coalition B articulated this with the following quote: "*That's how decisions are generally made, always based on the mission. Knowing who we are informs everything and knowing what in the past, what structure we decided will work.*" When asked

about their decision-making process, coalition leadership discussed the development of coalition action plans and logic models, citing adherence to the Strategic Prevention Framework. Their specific decision-making process was described as following two lines. Decisions related to policies and actions within the community are made by the Board, with accompanying discussion, voting, and action. Other types of decisions are made within the general coalition membership or task forces and are reached by group consensus.

Coalition membership. A total of 14 members from Coalition B completed the member survey, representing seven of the included ten community sectors. No individuals from law enforcement, the judicial system, or the faith community participated in the surveys. Survey respondents from Coalition B reported an average of over five and a half years of experience working with their coalition. Sixty-four percent of respondents indicated attending at least half of the coalition meeting over the previous year and 100% of respondents indicated that they had experience talking at meetings. In addition, nearly 79% of respondents reported that they had served on a coalition task force or committee within the previous year. When asked to rate the overall level of engagement of coalition members across the twelve community sectors identified by DFC, coalition leaders rated state and local and/or government agencies, healthcare professionals, and law enforcement agencies as *highly involved.* Out of the twelve sectors, media was rated the lowest, at *minimally involved.*

In their interviews, coalition leaders agreed that coalition member engagement will vary depending on what is going on around the community or within the coalition. One leader identified time constraints as limiting member engagement and discussed a desire for coalition activities to be more volunteer-driven versus staff-driven, but said that coalition members are there whenever the coalition needs help with something. Leaders also discussed specific

strategies they use to encourage member engagement, such as making the meetings action-oriented, engaging in small group activities at the meetings, and using more unconventional methods to recruit new volunteers.

Interpersonal relationships. Coalition B membership rated coalition cohesion and leadership communication relatively highly. Interviewees also agreed that coalition relationships were strong, describing their membership as being "*on the same page*" and "*very friendly*." When asked to describe the relationships between coalition members, one leader responded:

> *Cordial, funny, hysterical. A lot of respect for the expertise in the room. There's a sense of, I know what I can bring to the table; if you need something let me know. Some are more laid back than others, but there is a sense of openness.*

Similarly, another leader stated:

> *You have a lot of very bright, very passionate people at your table and the fact that they can agree on particular strategies always strikes me. Because we come to a compromise position and for some of them, compromise does not come easily. They have leadership roles in their agencies or what have you and they're not necessarily used to saying 'okay let's do it your way, let's try that'.*

Leaders were also able to identify several communication methods used within the coalition, including: small and large group discussions at meetings, surveys to gain feedback, and newsletters and email updates. They also stated that the exchanging of contact information is a common occurrence at coalition meetings.

Some level of conflict was also described in surveys and leadership interviews. The surveys indicated low levels of conflict, with a total conflict subscale score falling between *some* and *not much*. Both coalition leaders were also able to give specific examples of conflict within

their coalition. In their discussions, both leaders pointed out that the coalition can address divisive community topics and that identifying coalition priorities sometimes creates conflict. Three separate examples of past conflict were shared by Coalition B leaders. In addressing this conflict, leaders discussed the importance of honest and open discussion, adhering to coalition policies and procedures, and speaking in one voice.

Participation benefits and costs. Through their participation in Coalition B, members emphasized the valuable relationships they have developed. They also reported fairly high levels of new skill development and gaining a sense of personal fulfillment through their participation. Respondents also indicated little coalition interference, in general, with their work responsibilities, family life, and personal free time. Leaders discussed roles of the coalition related to building capacity and fostering relationships, and cited time as a potential interference for community member participation.

Community support. Coalition members rated community support as moderate. Similar to conflict, community support is one of the coalition functioning areas that may need improvement. Leaders described community support of the coalition as varied. Both leaders believe that many of the key leaders within the community know who they are and are supportive of what they do, but that average citizens might not. As one leader discussed:

> *Everyone [referencing the general community public] knows who the players are in the [county name], the [local high school] football team much more than they know who we are. Professionally, yes. Community, I would say we are, 30% of the people if you ask them would know who we are.*

Challenges associated with community support included: the size of the community, a lack of interest from the average citizen, and a lack of citizen time. Across the interviews, the support

from county government was cited most often. Coalition leaders emphasized the strength of having an office located with the county administration building, having built a relationship with the county commissioner and other county officials, and having access to county data. Leaders were also able to identify specific instances in which key community agencies have collaborated with them to address community issues.

Leadership. In the surveys, coalition members rated their leadership's style, competence, and skill highly. When asked about perceived level of influence in coalition decision-making, 50% of respondents indicated that they had some level of influence, while 43% believed they had either a lot or a great deal of influence. In the interviews, leaders held very positive perceptions towards each other and demonstrated an empowering leadership style on several occasions. They made several comments about being open and inclusive in the coalition, turning to coalition partners for their feedback, suggestions, and expertise, having leadership take turns running the coalition meetings, and acknowledging and celebrating coalition member successes. Representative quotes included: "*It's great, partners have great ideas. Because we get old and we get stagnant, it's important that we get other ideas, and start looking at things differently*"; "*We actually ask them…What's working, what's not working, what do we need to do, who's missing from our table?*"; "*Nobody's afraid to say what they think or to ask a question*"; and "*We try to highlight them. They are the reason we get the work done. So rather than them just doing the work and not be acknowledged, we recognize that people do the work for a lot of different reasons*." The interviews also shed some light on leadership's competence. Leaders had extensive experience working with community coalitions, were able to identify many key community "players" and implied working relationships with these individuals, were familiar

with key community and coalition issues, discussed their ability to deal with difficult situations and manage conflict, and were familiar with current prevention strategies. One leader stated:

> *[county government leaders have] a lot of respect for our expertise, we've helped write ordinances, we have done all kinds of stuff. We have worked hard to leverage our reputation, which we're not going to give up without a fight, we're very careful.*

Prevention activities. In the surveys, the members of Coalition B reported positive attitudes toward community-based prevention programming and reported some level of knowledge of EBPs. Coalition leaders identified a variety of specific strategies and/or activities that they have experience with, including: information dissemination and education, providing trainings, the prescription drug take-back events, production of county-level reports, media campaigns, community surveying, implementing prevention curriculum, and working towards policy change. They identified education and information dissemination as major strategies, but reported policy change as getting "*the biggest bang for your buck*". Coalition leaders were familiar with specific EBPs and reported some experience working with EBPs, but noted several challenges which will be discussed in detail later in the Chapter.

Coalition C. County C represents the second smallest county included in the present study, with a 2010 population of 464,607 people (U.S. Census Bureau, 2010). An estimated 21% (98,488 individuals) of the population of County C is under the age of 18 years-old with child poverty rates approaching 21% (The Annie E. Casey Foundation, 2014). Coalitions C was the youngest and smallest coalition included in the present study, consisting of approximately 40 active members and maintaining one full time and one part time staff members. *Active members* were defined, according to coalition leadership, as members who attended at least four coalition meetings over the previous twelve months. Across all of the coalition definitions, the definition

of *active membership* given by Coalition C leadership was the most restrictive. The coalition was established in 2006, with support from local behavioral health treatment providers, school officials, and law enforcement. With funding from the state, Coalition C initially focused on community issues related to underage drinking and DUI. In 2009, Coalition C received its first DFC grant and expanded its efforts, hiring a coalition coordinator, forming new subcommittees, and expanding coalition priorities. The coalition currently operates within a behavioral health treatment provider in their county. This agency manages the coalition finances and many of its policies and procedures. Coalition C, however, has established a Board of Directors and has created its own vision and mission statements. The major goal of the coalition is to reduce substance abuse in the county, with a focus on youth. More specific goals of Coalition C, as articulated by its coordinator, are to reduce underage drinking, impaired driving, prescription drug overdose deaths, and the prevalence of substance exposed newborns and to increase the perception of harm of marijuana use among youth. The coalition received an estimated $200,000 in funding from three sources to support coalition activities over the previous year.

Formalization. As stated above, Coalition C has a Board of Directors which acts as a governing body and oversees staff hiring and evaluations. Most policy decisions are made within the behavioral health agency that houses the coalition. Coalition C contains six task forces, focusing on alcohol use, prescription drug abuse, substance exposed newborns, marijuana use, community resources/health and wellness, and assessment and evaluation. The coalition also has a youth committee and one full-time staff member, the coalition coordinator. Each task force has a volunteer chairperson.

Two types of coalition meetings were described by the interviewed leadership: general coalition meetings and task force meetings. Leaders described the general meetings, which occur

monthly, as less formal and action-oriented. These meetings work off of an agenda and typically start with introductions and review of meeting minutes, followed by a community guest speaker/presentation, community report outs, and a discussion on current data, initiatives, priorities, and next steps. At the end of the meeting, a round table discussion occurs where coalition members can give any announcements that they have. Coalition general meetings are facilitated by the coalition's chair. Task force meetings were described as "*where the rubber meets the road*" and serve to work on strategy planning and implementation. These meetings are run by each task force chairperson.

Task focus. Coalition board efficiency and directedness were rated highly by Coalition C members in the surveys. Coalition leaders agreed on the overall goals of the coalition: to reduce substance use within their county by addressing the task force issues. Logic models and action plans are developed in each task force to contribute to greater task focus. Decision-making procedures were described as varied according to topic. According to leadership, many of the funding, marketing, and policy decisions are made by the behavioral health agency that supports the coalition, staff and evaluation decisions are made at the Board level, and decisions regarding initiative priorities are made at the coalition or task force level. Decisions made at the Board level follow more formal voting procedures, while coalition and task force decisions are made through discussion and group consensus. Both leaders described a similar decision-making process and the Strategic Prevention Framework was cited to help guide decision-making.

Coalition membership. A total of 22 individuals from Coalition C completed a coalition member survey, representing nine separate community sectors. Survey respondents had a mean of three years of experience working with Coalition C. Sixty eight percent of survey respondents indicated attending at least half of the coalition meetings over the previous year, with 81%

reporting talking or expressing ideas at these meetings. Nearly 64% of respondents also reported that they had served on a coalition task force within the previous year. Coalition leaders possessed high levels of agreement regarding the involvement of the twelve community sectors identified by DFC. Both leaders rated youth-serving organizations, law enforcement agencies, healthcare professionals, and state and local and/or government agencies as highly involved in coalition activities. Both leaders also agreed that the business community was the least involved community sector.

Coalition leaders described member engagement in their interviews as "*above average*", but with "*room for improvement*". They said that the task forces help with member engagement, by allowing members to choose specific activities that they are most interested in, but that some task forces are stronger than others. They also described the need for active involvement in the coalition. For example, when referring to member engagement one leader made the following statement:

> *This is not one of those committees or groups where you just show up and listen. This kind requires active involvement. Sometimes you do active involvement kind of activities in the monthly meeting. We'll get things out and divide them up into groups, and you don't want to just listen, it's not a meeting to do that. So I think it's setting that philosophy, that precedent, but it's only for the actively involved*.

Interpersonal relationships. Members reported high levels of cohesion and communication and low levels of conflict in their coalition. In their interviews, leaders described member relationships as "*strong*". They also described their members as passionate and actively involved. The following statement was made by one of the leaders to describe member relationships: "*there's no kind of competition. You know I think we all play nice. Maybe it's*

because we're a solid county, I don't know. I think relationships are very strong among our members and everyone communicates well." She goes on to say that "*people are honest and respectful, trustworthy, and I think that makes for a good recipe for people to just get along*."

Coalition leaders also identified several ways in which they and coalition members communicate with each other, including: discussion at meetings, emails, telephone calls, and collecting feedback through surveys. When asked about conflict, coalition leaders differed in their responses. One leader provided specific examples of coalition disagreements surrounding occasional "*finger-pointing*" among members. The other leader acknowledged disagreements, but described them as "*honest discussions*." Although both leaders stated that coalition members may not always see eye-to-eye on certain coalition issues, they believed the coalition is able to successfully act as a "*buffer*" and help members "*realize the benefit of getting along with people".*

Participation benefits and costs. When asked about perceived benefits, 100% of respondents reported gaining at least *a little* benefit in learning new skills, developing valuable relationships, and obtaining a sense of personal fulfillment through their participation with the coalition, although a large portion of respondents reported *a great deal* of benefit in these areas. Sixty percent of respondents indicated almost no interference with work responsibilities due to their participation, while more than 80% of respondents indicated almost no interference with family life and personal free time. In the interviews, leaders discussed member benefits related to networking and making a difference in the community. As quoted from one leader: "*I think the people that have been involved with it in some way think it's a definite benefit, and are inspired that we need prevention efforts out there, and that prevention can work*." No real difficulties associated with participation were discussed by interviewees.

Community support. Coalition members rated community support relatively high in the membership surveys. Coalition leaders identified both strengths and challenges related to their community's support. When asked about community perceptions of the coalitions, leaders agreed that they have made progress in this area, but there are many community members who are unaware that the coalition exists. They did, however, think influential community leaders are aware of the coalition and use the coalition as a resource. Examples of community support described in the leadership interviews included outside community agencies: providing funding, collaborating on grant proposals, making it easier for staff members to attend meetings, looking to the coalition for information or the latest data, agreeing to present at coalition meetings or events, and attending coalition trainings or events. Challenges or gaps related to community support included: the large size of the county, a lack of city council member awareness of the coalition, and difficulties recruiting businesses for safe vendor service trainings. Across the interviews, the behavioral health provider agency housing the coalition was acknowledged most often for their support of coalition activities, followed by law enforcement and the health care sector.

Leadership. Leadership style, competence, and skill were all rated highly by members of Coalition C. Fifty five percent of coalition members surveyed felt they had some influence on coalition decision-making and 41% felt that they had *a lot* or *a great deal* of influence. Leadership style and competence was also inferred from the interviews. In the interviews, leaders consistently spoke of the importance of being inclusive and accepting, celebrating successes, turning to members for suggestions or expertise, and including coalition volunteers in leadership roles. For example, one leader stated in her interview that:

I think it's important that our coalition makes all opinions feel validated, our people feel validated, and opinions needed at the table so that we can work together. I think our successes and highlighting successes and making sure that we celebrate successes of the group has helped us engage members and keep members attending.

Leaders also spoke frequently about using their partners as resources to help support coalition activities through: turning to them for data, identifying new trends or priority issues, and making important decisions. Leaders demonstrated high levels of knowledge regarding coalition activities and community needs, skills in conflict resolution, openness for learning new prevention skills, communicating with members, and identifying key community leaders.

Prevention activities. Out of all the constructs measured through the coalition member surveys for Coalition C, attitude and experience with prevention programming was rated the highest. Nearly all respondents indicated that they believe school-based prevention programming is beneficial and that substance abuse prevention programs are a good investment. Most respondents were also familiar with the term *evidence-based program* and many individuals reported some familiarity with specific EBPs. Coalition leaders identified a variety of prevention activities and strategies that they have been involved with. Both leaders were also familiar with the seven change strategies described by CADCA (CADCA National Coalition Institute, 2009).

Coalition D. The final coalition included serves the second largest county participating in the current study, with a total county population of 916,542 (U.S. Census Bureau, 2010). Nearly 18% (160,731 individuals) of County D residents are under the age of 18 years-old, with a child poverty rate of 21.4% (The Annie E. Casey Foundation, 2014). Coalition D was established in 2003, led by the Department of Juvenile Justice. More recently, a local nonprofit behavioral

health agency agreed to become the coalition's managing entity. Currently, the coalition has four staff members. The overall mission of Coalition D, as articulated in the interviews, is to reduce underage drinking and increase awareness and education in their community. According to leaders, this has been the mission of the coalition since its establishment. Although alcohol is the coalition's major focus, they have additional goals related to decreasing juvenile fatalities and substance exposed newborns. The coalition also tracks data related to county drug trends, including marijuana, synthetic drugs, and prescription drugs. Supporting and expanding the coalition's youth groups was an additional goal emphasized by both leaders. Last year, the coalition received approximately $450,000 in funding from three separate sources.

Formalization. Coalition D currently operates under the behavioral health agency mentioned above. This agency serves as the coalition's fiscal agent. The coalition also has a key leadership council who has been selected to vote on coalition issues. This leadership council includes a coalition chair, vice chair, secretary, and treasurer. The coalition is further divided into five workgroups that focus on needs assessment, resource and capacity assessment, community action planning, implementation, and monitoring and evaluation. Each of these workgroups is led by a volunteer chair.

Coalition meetings were described as highly structured. The key leadership council meets monthly to provide updates and discuss and vote on coalition decisions. Although all coalition membership is invited to attend these meetings, only members of the leadership council may participate in the voting. The meetings are facilitated by the coalition chair and begin with introductions and a review of previous meeting minutes. Following this is a presentation, usually on topics related to a new program or current data trends. Each workgroup is then given time to update the council on their activities and/or announce any upcoming events. The meeting ends

with an open member discussion, any final announcements, and a reminder about upcoming events. Workgroup meetings were described as less structured and vary depending on what is current for them at the moment. They are facilitated by the workgroup's chair and can take place either in-person or by telephone.

Task focus. Coalition members rated the efficiency and directedness of their leadership council highly. Interviewees agreed upon the overall mission of the coalition: to address alcohol issues and reduce underage alcohol use within the community. They were also both able to successfully describe each of the coalition's workgroups. Clear decision-making procedures were discussed. Each workgroup has been designed around a piece of the Strategic Prevention Framework. Logic models and action plans have been developed for each of the coalition's objectives, which are identified, discussed, and revised each year. Coalition issues are discussed monthly at the key leadership council meetings. At these meetings, the information is presented, the council has a discussion, and then they have a vote.

Coalition membership. A total of 18 individuals from Coalition D participated in the coalition member surveys. All ten community sectors included in the surveys were represented in the membership surveys. Respondents indicated a mean of 4.7 years of involvement with Coalition D. Nearly 56% of respondents reported attending at least half of the coalition meetings within the previous year and the majority of respondents (83%) reported talking at coalition meetings within the past year. Nearly 63% of respondents also reported serving as a member of a coalition workgroup over the previous year. Coalition leaders indicated high levels of involvement across most of the twelve community sectors outlined by DFC. Specifically, both leaders agreed that youth, the business community, the media, schools, youth-serving

organizations, and law enforcement agencies were *highly involved* in their coalition. Parents and the state and local and/or government agencies were rated the least involved by coalition leaders.

Coalition leaders specified that one of their workgroups, focusing on resource and capacity assessment, is charged with member recruitment and engagement. They also mention that engaging members on specific committees help with member participation. When asked to describe member engagement one leader indicated that:

> *Overall it's good. It had some changes over the years, you know people have come and gone, but we do have a core group of people that have been involved for several years. So I think it's good. We generally have active participation in our meetings and in our activities outside the meetings. Although we don't necessarily have a lot of them, we do tend to get some coalition members who will participate.*

The leader went on to say that they (the coalition) need to work on recruiting and encouraging new member involvement and that is something they try to do on an annual basis.

Interpersonal relationships. Out of all the coalition functioning domains examined by membership surveys, those related to interpersonal relationships (i.e., communication, cohesion, and conflict) had some of the lowest ratings. However, these ratings were still overwhelmingly positive. Coalition leaders identified several different communication methods used within their coalition, including: in-person meetings, conference calls, email newsletters, and other email correspondences. When asked about the frequency of communication between coalition members, leaders indicated that most of the coalition work happens outside of the meetings, but they were not sure how often they communicated with each other. Leaders also agreed that members general get along well with each other and that they are committed to the coalition

vision. Both leaders indicated that little conflict occurs within the coalition. For both cohesion and conflict, no specific examples were provided by coalition leadership.

Participation benefits and costs. When asked about perceived benefits of coalition participation, all members of Coalition D reported at least *A Little* benefit in regarding to learning new skills and developing valuable relationships. Most members also reported gaining some sense of personal fulfillment through their participation. Many individuals reported *A Great Deal* of benefit across these three dimensions. When asked about participation difficulties, almost 70% of survey respondents reported little or no interference with their work schedule and almost all respondents (94%) reported little or no interference in their family life or personal free time. Interview respondents discussed capacity building, through workshops and seminars, as potential benefits to participation. They did not identify any specific participation difficulties.

Community support. Coalition members rated community support highly in the membership surveys. Leaders also described a "*good*" community perception and discussed specific ways in which the community has supported coalition activities in their interviews. The coalition is often asked by community leaders to participate in community events. In addition, many of the area schools and other organizations have worked with the coalition to implement youth groups. Many community agencies have also partnered with the coalition to implement various strategies. For example, law enforcement partners with the coalition to implement their compliance checks. One challenge described by coalition leaders was a lack of awareness within the general community of the coalition; however they agreed that influential community leaders support the coalition. Across both interviews, the support from local behavioral health providers in the community was emphasized.

Leadership. The style, competence, and skill of coalition leaders were rated highly by coalition members. Most coalition members (89%) also reported feeling that they have at least some influence on coalition decision-making. Nearly 39% of members reported having *A Lot* or *A Great Deal* of influence in coalition decision-making. Leaders also demonstrated an empowering leadership style in their interviews. They emphasized being open to member input and described the importance of recognizing hard work amongst coalition members. As one coalition leader put it: "*the goal [is] to involve everyone. It's not just a social problem, it's not just a law enforcement problem, it's society's problem*." Leadership competence was also demonstrated. Both leaders were knowledgeable and respected in their fields and they both have previous experience as supervisors or leaders in their agencies. They were also able to identify many of the leaders within their community and spoke of developing working relationships with many of these individuals. One leader had extensive experience working in the prevention field and was familiar with many prevention strategies.

Prevention activities. Members of Coalition D indicated positive attitudes toward prevention programming. In addition, the majority of members (69%) reported that they *Strongly Agree* that they are familiar with specific substance abuse prevention programs. Most members were also familiar with the term *evidence-based program* and many indicated some knowledge of specific EBPs. Leaders discussed many different types of prevention activities that the coalition is involved with. These included: town hall meetings, participation in community events (e.g., Walk Like MADD, Operation Medicine Cabinet, Red Ribbon week), formation of school- and community-based youth groups, information dissemination and education, compliance checks, and policy change activities.

Coalition Comparisons

The following section of Chapter Four discusses similarities and differences across the coalitions in their background and functioning. Coalition use of EBPs is discussed in a later section. The emphasis of discussion is based on the information gained through the key leader interviews, as no significant differences in the coalition functioning domains emerged across coalition member surveys (see Table 5). As shown in Table 5, members rated their coalitions highly across most coalition functioning domains. Table 6 illustrates the identified themes and a few representative quotes observed in coalition leader interviews related to their coalition's functioning.

Table 6. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Background - DFC Funding Impact	• *"allowed us to look at what we were doing and how [we were] doing it…[we] decided to change that system."* • *"That's when we started really getting momentum, that's when we were able to hire a coalition coordinator, and that's how it really started getting going."*
Background - Goal Expansion	• *"Goals haven't necessarily changed, but they've expanded. Based on community need…"* • *"I think the goals remain constant, but….we have broadened our outreach."*
Funding Vs. Community Priorities	• *"Both funding streams made underage drinking and DUI a priority, but the community was saying pills were an issue…So despite not having funding, we were able to make that a priority."* • *"It's partly environmentally driven, it's partly funding driven."*
Formalized Meeting Procedures	• *"The chair facilitates the meeting and if she's not there the vice chair does."* • *"We have an agenda. Often times we have a guest speaker. You know, approve are minutes, that kind of stuff. And then we go through committee updates."* • *"…things are discussed at the meeting and then we vote on it."*
Decision-Making Procedures	• *"The decision-making process is really based in the coalition, so do we form a committee? And then the committee makes a lot of the decisions moving forward on the logic model, action plan, SPF process, coming back to the coalition for approval or input each step of the way."* • *"Someone will present an idea, we have a discussion on it, then we call for a motion if necessary or we call for a vote on that and if there is consensus, then the decision is passed and we move on."*
Decision-Making - Data	• *"As data becomes available they [action plans] are updated."* • *"Through statistics, through surveys. Surveys are done in schools. Statistics are gained through emergency room, the poison control center, various different resources, and it's all pull together."* • *"Everything we do is data-driven."*

Table 6 Continued. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Decision-Making - Member Passion / Public Outcry	• *"Do we have the people who are passionate about doing it?"* • *"It might be again that public outcry or people seeing issues too, just hearing about trends in the community."* • *"Because the community and the coalition has said this has value for us, so they'll continue with that."*
Decision-Making - Funding /Resources /Capacity	• *"Resources to provide it, man power, funding if it's needed."* • *"…whether or not it's doable logistically, if the coalition has enough people to get involved, if they have the money to do it."* • *"Sometimes it's a funding initiatives. At some point give us funding to address something."*
Decision-Making - Grant Requirements	• *"To some extent you have to see the grants you get. If there are certain things that they tell you have to do, you have to do that."*
Decision-Making - Coalition Fit	• *"If it fits within the mission…and if there's a benefit to the community"* • *"…it makes sense and it fits in with our mission"* • *"That's how decisions are generally made, always based on the mission. Knowing who we are informs everything"*
Member Engagement - Through Task Forces	• *"…would get them in the task force because that's really where the work is done."* • *"We ask involvement in the committees. We ask you not only to participate in the coalition, but to be involved in the committees."*
Member Engagement - Highlight Successes	• *"I think our successes and highlighting successes and making sure that we celebrate successes of the group has helped us engage members and keep members attending."*
Member Engagement - Being Open and Inclusive	• *"I think it's important that our coalition makes all opinions feel validated, our people feel validated, and opinions needed at the table so that we can work together."* • *"making sure that people feel that they are welcome to provide information."*
Member Engagement - Being Action-Oriented	• *"Working at the meeting, so not making it a meeting where there's just a report outs but making something actually happen at the meeting."* • *"Sometimes you do active involvement kind of activities in the monthly meeting."* • *"…we do a lot of activities our coalition meeting that are like icebreakers, and energizers to get people to feel that ownership."*
Member Engagement - Communication	• *"…try to spread the word to all the other places I go out in the community."* • *"…we actively asked people, we seek people."*
Conflict - Partner Disagreement	• *"…there is still finger-pointing, especially when a new issue comes up, the schools aren't doing enough, the parents aren't doing enough, law enforcement is not doing enough, doctors aren't doing enough. So everybody can point a finger and say someone is not doing enough."* • *"…it may not be everybody's opinion. I may hear an opinion that's different than someone else's"*
Cohesion	• *"This is their passion, people really care."* • *"They are very comfortable talking with each other."* • *"…people are honest and respectful, trustworthy."* • *"…the willingness to share resources and information is huge. I think there's a trust that's built up."* • *"Nobody's afraid to say what they think or to ask a question or to say I help with this."*

Table 6 Continued. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Participation Costs - Member Time	• *"…people's time. I don't know anybody who doesn't feel like they're maxed out on the stuff they have to do."* • *"…we are not pulling away too much of someone's time. Typically when you find someone who was involved in a coalition and they are active, they are usually involved in something else as well."*
Participation Benefits - Networking	• *"I think there's a networking piece that, I think people have met people that they wouldn't necessarily know otherwise."* • *"Networking seems to be one of the main things…that it is a priority for them to have some time to network."* • *"We encourage networking…people come a little early… people can stay for an extra hour just talking afterwards."*
Participation Benefits - Building Skills / Capacity	• *"…building the capacity of the members of that committee."* • *"We do quite a bit of enhancing skills too, we do several trainings at conferences."* • *"We have had several trainings this year…We also send staff members and members themselves to CADCA. For the midyear training Institute we're sending board members and some staff members."*
Participation Benefits - Community Change	• *"…to feel like they've got a place where they can come and make an impact."* • *"That is empowering them, to give them a focus."* • *"They feel like they're making a difference in their community."*
Lack of Community Awareness	• *"We have a big community… I think we are more well-known than we used to be, but I think there's still a lot of 'what is [coalition]?, I've never heard of [coalition], what do you do?'…we haven't infiltrated every realm out there"* • *"Out in the community…you meet some people who know you and others never heard of you before. So it's a huge County. It's a lot of people to reach and a lot of people don't know yet."* • *"… it would probably be an unknown perception, which is kind of a weird saying. They don't know enough about it."*
Support by Community Leaders	• *"We've had community leaders write us into special projects for additional funding, or prioritize some of our priorities so more staff of theirs can attend the meetings, or be part of the implementation and planning efforts."* • *"Whatever level of involvement we asked for, they seem to say yes to. Even within their busy schedules."* • *"…policymakers know who we are, law enforcement knows who we are, you know providers know who we are in the professional community."*
Coalition as a Community Resource	• *"Using us as a resource…for example the health department, doing their community health improvement plan, definitely leans on us for the substance abuse component, which is great."* • *"[coalition name] is seen as kind of the hub of data, the hub of prevention. "* • *"You know people look to us for data…I think people come to us for that resource for all those prevention activities."*
Empowering Leadership Style	• *"I think our successes and highlighting successes and making sure that we celebrate successes of the group has helped us."* • *"Every time I see a new member, I'm going introduce myself and try to make them feel welcome."* • *"We will ask them, if we need something and it is their area of expertise…we will ask them to present on it and inform us, so that we are kept up-to-date."* • *"We have awards we give to people…where we identify members who worked very hard or notably in an area…"* • *"Were always asking them what are you seeing? What are you hearing? What are the current issues?"*

Table 6 Continued. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Leadership Competence	• *"I go to a lot of different meetings, I go to Mothers against Drunk Driving, I go to the community traffic safety team…"* • *"We'll go out and get trained on things and find out about it."* • *"…the city attorney will call [leader] up, she even has [leader's] number."* • *"We've been successful in moving the coalition from basically a small community driven events-based piece to much more strategy driven, much more political savvy…"* • *"we've helped write ordinances, we have done all kinds of stuff. We have worked hard to leverage our reputation."*
Strategy - Providing Information	• *"I think that most coalitions, the bread-and-butter is probably providing information."* • *"A lot of what we do…is providing information."* • *"Information and education are our primary role."*
Strategy - Changing Policy	• *"we have found that the best way to make a difference is modifying and changing policies."* • *"Policy is the holy grail."* • *"changing policies is always our ultimate goal. So anything that we can get towards changing a policy, whether it's within organization or across the County. It's always an ultimate goal."* • *"I like to focus on policy. I just feel like that has the biggest impact."* • *"This is the one that probably gives you the biggest bang for your buck."*
Strategy - Changing the Physical Design	• *"the physical design is one of the hardest things for us to do as well…we don't spend a lot of time there."* • *"The physical design, that's probably the least that we have had impact in."* • *"probably the least amount of emphasis is on physical design."* • *"The one that is probably the least, number seven on our list would be physical design. We haven't done much."*
Decision-Making Procedures	• *"The decision-making process is really based in the coalition, so do we form a committee? And then the committee makes a lot of the decisions moving forward on the logic model, action plan, SPF process, coming back to the coalition for approval or input each step of the way."* • *"Someone will present an idea, we have a discussion on it, then we call for a motion if necessary or we call for a vote on that and if there is consensus, then the decision is passed and we move on."*
Decision-Making - Data	• *"As data becomes available they [action plans] are updated."* • *"Through statistics, through surveys. Surveys are done in schools. Statistics are gained through emergency room, the poison control center, various different resources, and it's all pull together."* • *"Everything we do is data-driven."*
Decision-Making - Member Passion / Public Outcry	• *"Do we have the people who are passionate about doing it?"* • *"It might be again that public outcry or people seeing issues too, just hearing about trends in the community."* • *"Because the community and the coalition has said this has value for us, so they'll continue with that."*
Decision-Making - Funding /Resources /Capacity	• *"Resources to provide it, man power, funding if it's needed."* • *"…whether or not it's doable logistically, if the coalition has enough people to get involved, if they have the money to do it."* • *"Sometimes it's a funding initiatives. At some point give us funding to address something."*
Decision-Making - Grant Requirements	• *"To some extent you have to see the grants you get. If there are certain things that they tell you have to do, you have to do that."*

Table 6 Continued. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Decision-Making - Coalition Fit	• *"If it fits within the mission…and if there's a benefit to the community"* • *"…it makes sense and it fits in with our mission"* • *"That's how decisions are generally made, always based on the mission. Knowing who we are informs everything"*
Member Engagement - Through Task Forces	• *"…would get them in the task force because that's really where the work is done."* • *"We ask involvement in the committees. We ask you not only to participate in the coalition, but to be involved in the committees."*
Member Engagement - Highlight Successes	• *"I think our successes and highlighting successes and making sure that we celebrate successes of the group has helped us engage members and keep members attending."*
Member Engagement - Being Open and Inclusive	• *"I think it's important that our coalition makes all opinions feel validated, our people feel validated, and opinions needed at the table so that we can work together."* • *"making sure that people feel that they are welcome to provide information."*
Member Engagement - Being Action-Oriented	• *"Working at the meeting, so not making it a meeting where there's just a report outs but making something actually happen at the meeting."* • *"Sometimes you do active involvement kind of activities in the monthly meeting."* • *"…we do a lot of activities our coalition meeting that are like icebreakers, and energizers to get people to feel that ownership."*
Member Engagement - Communication	• *"…try to spread the word to all the other places I go out in the community."* • *"…we actively asked people, we seek people."*
Conflict - Partner Disagreement	• *"…there is still finger-pointing, especially when a new issue comes up, the schools aren't doing enough, the parents aren't doing enough, law enforcement is not doing enough, doctors aren't doing enough. So everybody can point a finger and say someone is not doing enough."* • *"…it may not be everybody's opinion. I may hear an opinion that's different than someone else's"*
Cohesion	• *"This is their passion, people really care."* • *"They are very comfortable talking with each other."* • *"…people are honest and respectful, trustworthy."* • *"…the willingness to share resources and information is huge. I think there's a trust that's built up."* • *"Nobody's afraid to say what they think or to ask a question or to say I help with this."*
Participation Costs - Member Time	• *"…people's time. I don't know anybody who doesn't feel like they're maxed out on the stuff they have to do."* • *"…we are not pulling away too much of someone's time. Typically when you find someone who was involved in a coalition and they are active, they are usually involved in something else as well."*
Participation Benefits - Networking	• *"I think there's a networking piece that, I think people have met people that they wouldn't necessarily know otherwise."* • *"Networking seems to be one of the main things…that it is a priority for them to have some time to network."* • *"We encourage networking…people come a little early and we always have, with like [task force name] people can stay for an extra hour just talking afterwards."*

Table 6 Continued. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Participation Benefits - Building Skills / Capacity	• *"…building the capacity of the members of that committee."* • *"We do quite a bit of enhancing skills too, we do several trainings at conferences."* • *"We have had several trainings this year…We also send staff members and members themselves to CADCA. For the midyear training Institute we're sending board members and some staff members."*
Participation Benefits - Community Change	• *"…to feel like they've got a place where they can come and make an impact."* • *"That is empowering them, to give them a focus."* • *"They feel like they're making a difference in their community."*
Lack of Community Awareness	• *"We have a big community… I think we are more well-known than we used to be, but I think there's still a lot of 'what is [coalition]?, I've never heard of [coalition], what do you do?'…we haven't infiltrated every realm out there"* • *"Out in the community…you meet some people who know you and others never heard of you before. So it's a huge County. It's a lot of people to reach and a lot of people don't know yet."* • *"… it would probably be an unknown perception, which is kind of a weird saying. They don't know enough about it."*
Support by Community Leaders	• *"We've had community leaders write us into special projects for additional funding, or prioritize some of our priorities so more staff of theirs can attend the meetings, or be part of the implementation and planning efforts."* • *"Whatever level of involvement we asked for, they seem to say yes to. Even within their busy schedules."* • *"…policymakers know who we are, law enforcement knows who we are, you know providers know who we are in the professional community."*
Coalition as a Community Resource	• *"Using us as a resource which I would like them to do that more, but I think for example the health department, doing their community health improvement plan, definitely leans on us for the substance abuse component, which is great."* • *"[coalition name] is seen as kind of the hub of data, the hub of prevention. "* • *"You know people look to us for data…I think people come to us for that resource for all those prevention activities."*
Empowering Leadership Style	• *"I think our successes and highlighting successes and making sure that we celebrate successes of the group has helped us."* • *"Every time I see a new member, I'm going introduce myself and try to make them feel welcome."* • *"We will ask them, if we need something and it is their area of expertise, of course we will ask them to present on it and inform us, so that we are kept up-to-date."* • *"We have awards we give to people…where we identify members who worked very hard or notably in an area…"* • *"Were always asking them what are you seeing? What are you hearing? What are the current issues?"*
Leadership Competence	• *"I go to a lot of different meetings, I go to Mothers against Drunk Driving, I go to the community traffic safety team…"* • *"We'll go out and get trained on things and find out about it."* • *"…the city attorney will call [leader] up, she even has [leader's] number."* • *"We've been successful in moving the coalition from basically a small community driven events-based piece to much more strategy driven, much more political savvy…"* • *"we've helped write ordinances, we have done all kinds of stuff. We have worked hard to leverage our reputation."*

Table 6 Continued. Coalition Functioning Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Strategy - Providing Information	• *"I think that most coalitions, the bread-and-butter is probably providing information."* • *"A lot of what we do…is providing information."* • *"Information and education are our primary role."*
Strategy - Changing Policy	• *"we have found that the best way to make a difference is modifying and changing policies."* • *"Policy is the holy grail."* • *"changing policies is always our ultimate goal. So anything that we can get towards changing a policy, whether it's within organization or across the County. It's always an ultimate goal."* • *"I like to focus on policy. I just feel like that has the biggest impact."* • *"This is the one that probably gives you the biggest bang for your buck."*
Strategy - Changing the Physical Design	• *"the physical design is one of the hardest things for us to do as well…we don't spend a lot of time there."* • *"The physical design, that's probably the least that we have had impact in."* • *"probably the least amount of emphasis is on physical design."* • *"The one that is probably the least, number seven on our list would be physical design. We haven't done much."*

Background. As demonstrated by the four case descriptions above, the coalitions varied in their background and general organization, with some commonalities across all. According to the National Center for Health Statistics' (NCHS) urban-rural classification scheme for U.S. counties, the counties served by Coalition A and D can be classified as "large central metro" areas, while County B is classified as a "medium metro" area and County C is classified as a "large fringe metro" (Ingram & Franco, 2013). The coalitions also differ in their age. However, although Coalition A was established in 1989, their work as a 501(c)(3) coalition did not occur until 2003. Coalition A also had the largest proportion of its population under the age of 18 years-old, along with the highest child poverty rate.

One common theme that emerged across several coalition interviews had to do with the impact of DFC funding on the coalitions' organization. Leaders from three of the four coalitions mentioned DFC funding at least once in their interview, even though there was no specific interview question directed at this topic. Leadership from these three coalitions described the

DFC grant award serving to push the coalition to the next level. See Table 6 for specific examples regarding how coalition leaders described the impact of the DFC program.

There were several commonalities in goals and objectives identified across the coalitions. Although coalitions differed slightly in their organization, all coalitions had an ultimate goal of reducing substance use in their community with a special focus on youth. When asked about how these goals progressed since the coalition's first establishment, coalitions discussed how goals expanded. As coalitions became more established and were able to obtain more funding, a greater number of community substance abuse issues were targeted. Coalitions talked about moving past goals specifically outlined by their funding agencies to those issues that were most important to community members. Specific objectives related to the same three substances were also identified across coalitions. Underage alcohol use was a major target issue for all coalitions, with secondary goals of addressing marijuana and prescription drug use.

Formalization. The included coalitions differed slightly in the way in which they are organized and their levels of formalization. Two of the coalitions (A and B) operate as independent 501(c)(3) nonprofit organizations, while the other two (C and D) are housed in community-based behavioral health provider agencies. However, all coalitions have established a Board of Directors or, in the case of Coalition D a key leadership council, in charge of setting coalition priorities and making strategy decisions. Coalitions have also developed several task forces or workgroups to organize their efforts around. Three of the coalitions have created task forces surrounding specific substances of abuse. All three of these coalitions have additional subcommittees that operate under their Board and deal with coalition business issues, such as fundraising. The fourth coalition has created workgroups, each in charge of a specific aspect

related to assessing needs, identifying strategies, implementation, and evaluation. All four coalitions discussed the presence of specific rules and regulations governing the actions of the coalition, whether under the Board or within a separate governing community agency. They also discussed formalized meeting procedures, such as regularly scheduled meetings, creation of a meeting agenda, identification of leaders to facilitate the meeting, review of meeting minutes, and voting procedures.

Task Focus. Differing levels of task focus were observed across coalitions. Coalition leaders were able to effectively articulate the mission and vision for their coalitions. The formation of task forces or workgroups, based upon this mission, helped organize coalition activities. Coalitions varied in the number of priorities addressed. For example, Coalition C leaders discussed six task forces; all focused on different substance abuse topics, while Coalition D organized their workgroups primarily around alcohol use issues within the community.

Generally, decision-making procedures were clearly defined across coalitions. Three of the coalitions described different levels of decision-making. Decisions surrounding coalition policy or procedures were typically made at the Board level, while strategy and implementation decisions were made more at the coalition or task force level. All coalitions mentioned following the Strategic Prevention Framework when making decisions. The coalition leaders also discussed the formation of logic models and action plans to guide coalition activities. Different factors were discussed that drive coalition decision-making and priority setting, as outlined in Table 6. These drivers included: data and community trends, member passion or public outcry, available funding, resources and coalition capacity, grant requirements, and perceived fit with the coalition's mission.

Coalition Membership. According to coalition leaders, individuals from all twelve community sectors outline by DFC are involved, to some degree, in each of the coalitions. Leaders varied, however, in how they rated the degree of involvement for each of the community sectors. Across all coalitions, leaders emphasized that member engagement is good, but could be improved. Methods to engage members identified by leaders included: introducing them to a coalition task force, highlighting coalition successes, being open and inclusive, making meetings action-oriented or activity-driven, and through continuous communication.

Interpersonal Relationships. Most leaders were able to identify at least one instance of conflict or tension within their coalition. Most often, the conflicts described were related to differences of opinion among coalition members, including disagreements around the priorities that are set or the strategies they use. All leaders, however, were able to discuss how the coalition worked to facilitate communication between the different community sectors, using words and phrases such as "*catalyst*", "*buffer*", "*honest discussion*", and "*ongoing education*". Despite the conflict, all leaders agreed that the relationships between coalition members were strong. Most leaders described several instances of positive member relationships, member closeness, and group spirit. Overall, leaders provided many more examples of cohesion within their coalition than instances of conflict. All coalitions were also able to describe various methods of communication between themselves and between coalition members. All coalitions mentioned discussion at coalition meetings, emails, and online newsletters. Several coalitions also discussed surveying coalition members regularly to obtain their feedback regarding coalition activities.

Participation Benefits and Costs. Across interviews, coalition leaders did not discuss any major costs or difficulties associated with member participation. Time was the only potential cost articulated by more than one of the coalition leaders. Leaders did, however, discuss several member benefits associated with their participation. Many leaders discussed networking opportunities provided through participation, skill and capacity building, and making positive community changes.

Community Support. Across coalition functioning domains, community support was most commonly rated the lowest by coalition members. Leadership interviews generally supported this finding. All coalitions articulated challenges related to the size of their community and reported a lack of awareness by general community members regarding the coalition. However, all coalitions also agreed that major community leaders were aware of the coalition and supported their activities. Coalitions were all able to provide examples of how they have partnered with community agencies on various events or projects. One common theme that arose across several coalition interviews was leadership's emphasis on being seen as a resource within the community.

Coalitions, however, stressed different community sectors when talking about community support. Coalition A emphasized support from law enforcement, Coalition B highlighted support they have received from county government, and Coalitions C and D emphasized help from the behavioral health provider agencies that support them. Coalition leaders also emphasized different community sectors in their pre-interview questionnaire. Three of the four coalitions indicated high levels of involvement from youth-serving organizations and law enforcement, two coalitions indicated high levels by local government agencies and healthcare professionals, and

one coalition indicated high levels of involvement of youth, the business community, media, and the schools.

Leadership. Leaders across all four coalitions demonstrated instances of an empowering leadership style. Leaders emphasized the importance of being open and inclusive and discussed several examples of turning to partners for their expertise. Several leaders also discussed the importance of celebrating partner successes and acknowledging member strengths. Coalition members, themselves, perceived having between some and a lot of influence on coalition decision-making. Leaders also demonstrated competence in several areas. All leaders were able to identify key leaders within their community and were aware of substance abuse issues within their community. Most leaders also reported previous experience serving in a leadership position. There was some variation, however, in prevention experience and knowledge among leaders. They also demonstrated some variation in their experience working with coalitions and the level of technical knowledge regarding coalition structure and organization (e.g., identifying funding sources, writing grants, navigating bureaucratic procedures).

Prevention Activities. All eight coalition leaders identified several strategies or activities that their coalition has been involved with in order to prevent substance abuse problems within their communities. Several of the same community events were mentioned across all four coalitions: law enforcement compliance checks, Walk like MADD, the NOPE Vigil, Red Ribbon Week, and prescription drug take back events. Many of them also talked about making posters and signs, setting up information booths or tables at community events, providing community trainings on prevention strategies, creating brochures or media ads, participating in city council

meetings, town hall meetings, and forming youth clubs in the schools. When asked about CADCA's seven strategies (CADCA National Coalition Institute, 2009), all four coalitions articulated that providing information is a major coalition activity, although most leaders emphasized that policy change is the coalition's major goal in most initiatives. All four coalitions also indicated the least amount of emphasis on changing the physical design in their community.

Evidence-Based Practice

The following section discusses coalitions' knowledge, attitude, and use of EBPs and effective implementation. Data are taken from both the coalition member questionnaires and the key leader interviews.

Coalition member questionnaires. Coalition member knowledge and attitudes toward EBP was assessed through the coalition member questionnaire. In general, most coalition members reported familiarity with EBP, with 78% of respondents reporting that they strongly agreed with the statement: *I am familiar with the term "evidence-based program".* The majority of respondents (58%) also strongly agreed that they were familiar with specific EBPs. Member attitudes toward the use of EBPs by their coalition or their coalition partners were also positive, with a mean overall attitude across all respondents of 3.82 (out of a possible 5.00). As shown by Table 5, there were no significant differences in EBP knowledge or attitude across the four different coalitions.

Bivariate correlations. Table 7 shows the results of the bivariate correlations between coalition functioning domains and attitudes toward EBP. Of interest in the current study are significant correlations between member attitude toward EBP and their perceived level of

coalition functioning. As shown by Table 7, coalition members who reported higher levels of community support and greater participation benefits were significantly more likely to report positive attitudes toward EBP ($p < .05$). Further, members with more positive attitudes toward program implementation support were significantly more likely to report positive attitudes toward EBP ($r = .51$, $p < .001$).

Key leader interviews. Coalition key leader interviews included several items intended to examine their knowledge, attitudes, and actual use of EBPs and effective implementation strategies. Table 8 illustrates the various themes identified related to EBP, along with examples of representative quotes.

Knowledge. Seven of the eight leaders were familiar with the term *evidence-based practice* or *evidence-based program.* All but one leader described EBPs as programs or practices that have some research support for their effectiveness. Some leaders, although familiar with the concept of evidence-based practice, demonstrated only a basic understanding regarding how programs or practices become evidence-based. For example, one leader defined an EBP as *"…knowing through, whether it's the intercept surveys, pre-and post-test, getting a baseline assessment and assessing again later whether change was made due to the strategies*". Several leaders went further in their definition, citing the quality of the research that should be conducted and the degree of evidence needed before the practice or program is deemed "evidence-based". For example, when talking about EBPs, one leader stated: *"…you can have your research printed, you just have to pay for it, so it's a certain level of research and which publication it appeared in…Just because it says research-based could fool some people*". Another leader

defined the research needed as "*rigorous*" and "*real hard to do*". The replicability and transparency of research was also discussed:

> *...did you put it out there for other people to review or replicate? Did you write to the prevention journals and put it out there so that there will be commentary to say, 'hey, did you think about this' or 'your science is kind of wrong here', so we can look at it from an objective point of view*.

Source and selection. Coalition leaders discussed several sources they would use to identify and select EBPs. Seven of the eight leaders identified SAMHSA or NREPP as a primary source for information about EBPs. SAMHSA/NREPP was the most frequently cited source for EBP information. Other sources that were identified, in order from most to least frequently mentioned across interviews, included: other coalitions or communities, Google or the internet in general, CADCA, CSAP, peer-reviewed journals, coalition partners, an internal EBP resource binder, and a college drinking website.

Leaders also discussed many factors that are important to them when selecting a new program or practice to implement. Most coalitions acknowledged the importance of choosing programs to match their target population and community issue of interest. Similarly, two coalitions discussed the selection of programs that have been researched or used in community environments similar to their own. Coalition leaders also selected programs that make sense to them. For several of the leaders, the types of strategies used, whether the program follows general prevention principles, and if the program seems "*well thought out*" were important deciding factors in program selection. The capacity to implement a program (e.g., skills needed, resources and time available) was also cited several times across interviews as an important determinant as was their perceived ease of implementation: *"...We may choose to implement a*

program or strategy without evidence of its effectiveness. If coalition members support the strategy and it requires few community resources…" Other important factors, articulated less often throughout the interviews, included: the source of the program or the research (e.g., "*who is recommending it?*", "*you have to know who paid for the research*"), coalition buy-in, effective program replication in the research, long-term evidence of effectiveness, opinions from colleagues and other coalition leaders, and whether or not there is a gap or need in the community (e.g., *"…we already have something like that here who they can partner with, you don't duplicate services*").

Experience. Across all coalitions, leaders emphasized that they do not normally implement prevention programs, but focus primarily on environmental strategies. As such, there were very few examples of coalition direct implementation of specific EBPs. One example of primary EBP sponsorship by a coalition was with the EBP, *Communities Mobilizing for Change on Alcohol* (CMCA). In reference to CMCA, one coalition leader stated: *"[CMCA] is an evidence based environmental strategy to reduce underage youth access to alcohol. We have been implementing that. We've had some small policy changes and we continue to work under that framework.*" Several instances in which coalitions support partner agencies in their use of EBPs were discussed. Two coalitions discussed working with partners to review current data and identify community gaps or needs that they could address with prevention programming. Coalitions also mentioned reviewing EBPs with their partner agencies and helping with the selection of programs that fit their community's need and the agency's capacity. One coalition discussed working with their partners to keep track of data regarding EBP reach (e.g., *"…being able to prepare reports and look at the data as far as number of students that are involved and…the substances that they are being picked up for*"). Finally, one coalition discussed working

Table 7. Bivariate Correlations among Member Reports of Coalition Functioning and Attitudes toward EBPs

Subscale	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. EBP Attitude (total)	--														
2. Leadership Style	.19	--													
3. Leadership Competence	.04	.80**	--												
4. Leadership Skill	.02	.83**	77**	--											
5. Community Support	.25*	.28*	.37**	.37**	--										
6. Efficiency	.02	.61*	.56**	.71**	.25*	--									
7. Leadership Directedness	.11	.68**	.75**	.61**	.40**	.46**	--								
8. Cohesion	.15	.63**	.53**	.64**	.58**	.50**	.52**	--							
9. Conflict[1]	.11	.37**	.35**	.27*	.34**	.23*	.29*	.50**	--						
10. Communication	.16	.42**	.45**	.34**	.10	.31**	.32**	.26*	.28*	--					
11. Participation Benefits	.26*	.56*	.37**	.49**	.40**	.33**	.39**	.66**	.33**	.25*	--				
12. Participation Difficulties[1]	.16	.09	.19	.09	.01	-.05	.01	.08	.11	-.19	.09	--			
13. Prevention Experience/Attitude	.06	.45**	.50**	.49**	.46**	.23	.36**	.47**	.44**	.01	.47**	.20	--		
14. EBP Knowledge/Experience	.01	.05	-.08	.10	.12	-.05	-.03	.14	-.07	.03	.07	-.08	.21	--	
15. Implementation Attitude	.51**	.17	.14	.00	.17	-.06	.14	.23	.24*	-.05	.23	.32**	.24*	-.10	--

*Correlation was significant at $p < .05$; **Correlation was significant at $p < .01$; [1]Indicates subscales which were reverse coded

with specific partners to find new ways to obtain funding to support an EBP. Specifically, the coalition discussed how they have worked with one of their community partners to identify new ways to obtain funding to support the expansion of the *Too Good for Drugs* prevention program into county high schools.

In addition to providing specific types of support to coalition partner agencies, several of the coalitions discussed their role in providing information to the community about the different types of EBPs being implemented across their community. Several coalition leaders have recruited speakers to present at coalition meetings on some of the EBPs they are implementing. Two of the coalitions also discussed their involvement in trainings and workshops on specific EBPs so they can provide information and support to any community partners who would be interested in implementing the programs themselves. Coalition leaders also discussed the importance of staying up-to-date with the EBPs currently being used by partners within their community.

Attitudes. Coalition leaders generally indicated positive attitudes towards the use of EBPs in their communities. In most instances, they stated that they strive to implement evidence-based programs or strategies as often as possible. For example, one leader made the following statement:

> *The emphasis on evidence-based I absolutely get, you know data is data. Good science is good science. You have to be able to prove what you said you were going to do actually did what it was supposed to do.*

However, leaders cited many challenges that inhibit their adoption of EBPs. All coalitions identified a lack of relevant community-based EBPs. Specifically, few environmental strategies have gone through the rigorous research needed to become evidence-based. Additionally, leaders

discussed a lack of fit of most EBPs to their community's unique needs: "*…you're trying to pretzel something into an environment where it really wasn't designed for*." Several leaders also discussed resource and cost issues: "*It costs a lot of money... it's a financial issue. Who can do that*?" One coalition identified challenges related to community buy-in for EBPs: *"…we like knowing that there's data behind something that somebody did, but sometimes we have to do what the community has the buy-in to do…*"

Identified programs. Across of all the interviews, leaders identified several specific EBPs, whether talking about programs they have used in the past, programs they have been trained for, or programs their partners have used. Out of all the programs discussed, the following were found on either the NREPP or the Blueprints for Healthy Student Development websites that were discussed in Chapter Two: *Active Parenting, Too Good for Drugs, Too Good for Violence*, *Communities Mobilizing for Change on Alcohol*, and *LifeSkills Training*. The most frequently mentioned programs were *Too Good for Drugs* and *Communities Mobilizing for Change on Alcohol*. Other programs that were mentioned, but were not found in the EBP databases above included *Face It* and *Let's Talk*. Both of these programs were described by coalition leaders as evidence-based prevention curriculums, although information regarding the evidence-base of these programs was not found. Coalition leaders also used the term *evidence-based* to refer to broad environmental strategies (e.g., CADCA's strategies) or to strategies that have not fully been evaluated.

Table 8. Evidence-Based Practice Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Knowledge - Basic	• *"…knowing through, whether it's the intercept surveys, pre-and post-test, getting a baseline assessment and assessing again later whether change was made due to the strategies."* • *"If we can identify a known source, reliable source for the strategy for the curriculum, we consider an evidence base."*
Knowledge - Advanced	• *"…you can have your research printed, you just have to pay for it, so it's a certain level of research and which publication it appeared in…Just because it says research-based could fool some people."* • *"…did you put it out there for other people to review or replicate? Did you write to the prevention journals and put it out there so that there will be commentary to say, 'hey, did you think about this' or 'your science is kind of wrong here', so we can look at it from an objective point of view."*
EBP Source – NREPP	• *"I would look on the NREPP site probably first as far as to research it."* • *"…SAMHSA has model programs or something like that, and has a list of evidence-based programs. Seeking going to the list, or you can just look up the individual programs you can find on it."*
EBP Source – Other Coalitions / CADCA	• *"CADCA is a good source of course, because it connects us with coalitions across the country so we can find out what works in your community, what doesn't work. When we meet in go to the CADCA meetings we exchange information, we learned a lot there."* • *"Would start with other coalitions to see what they are doing, placing into practice. You would look across the country to see what they have utilized and exercised."* • *"We will go to CADCA. Promising strategies that have come about through other coalitions. They have a gap outcomes program which identifies coalitions that have had effective strategies, that are currently on the road to becoming evidence-based."* • *"…we will go with the cutting edge coalitions, let's see what's working with other coalitions, with similar populations are targeted audiences. Because that's really clear."*
EBP Source – Internet	• *"I would just research it online. Like I said, I would just research it online."* • *"I would use Google."* • *"…you would start with the net."*
EBP Source – CSAP	• *"CSAP is a good source for that."* • *"Those kinds of strategies that SAMHSA or CSAP, that they release, we consider evidence-based."*
EBP Source – Journals	• *"Will go through peer-reviewed journals."* • *"Peer-reviewed journals, journal of science, Journal of prevention, they'll have components of that."*
Choosing Programs to Match Population	• *"…it depends on the population, the substances or trying to address, how much time they have, if they have a closed audience, if it's an open audience."* • *"That would really just be based on what makes sense for your community, what substances are being used, what age group you're trying to address."* • *"I would have to question that he what their goals are, what they want to do, what they are trying to achieve."*
Programs that Make Sense	• *"…the type of strategy that it is you know there are some things, they are some basic prevention strategies that are effective and so programs may incorporate those, so that shows that they are well thought out and follow general prevention guidelines."*

Table 8 Continued. Evidence-Based Practice Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Implementation Capacity	• *"We also talk at our own group, on what our strengths are and what we can do."* • *"Once we identified a problem in with go after it would look at what makes the most sense for this County given our resources, both fiscal and human resources, what can we really get started what can we do."*
Strategies, Not Programs	• *"we just support programs, we don't implement them. Evidence-based practice, we don't do programs, we do strategies."* • *"…so the coalition doesn't provide prevention curriculum and anything like that. We're community focused."* • *"We don't do programs quite as much, but we support those on the community."*
Partner Support – Identifying Needs	• *"we work with our partners…helping them understand, we have had lots of meetings with providers around research-based and looking at what fits. Our main provider here is [agency] so we would meet with them and look at this is our data from our County."*
Partner Support – Selecting Programs	• *"We work with them in terms of what they are selecting."* • *"[agency] [grant name] gets Active Parenting and Too Good for Drugs. They would come in here, I think when I first came I had these curriculums and they came in and were looking at it, so we were talking about it. We had a mutual knowledge of it, we're looking at that as a feasible idea. Because the other issue with research-based programming is can you afford to do it? So then you start looking at research-based strategies, which the strategies can implement? If you can afford to buy a curriculum."*
Partner Support – Program Tracking	• *"…being able to prepare reports and look at the data as far as number of students that are involved and…the substances that they are being picked up for."*
Partner Support - Funding	• *"Evidence-based programming says that one time doesn't do it. You should get them here and then hit them again here. We used to have that, we must funding. The high school program went away. The only have it in middle school. As a coalition, we need to advocate for the fact that we need in both places for it to be effective, so how do we work with the community and get that there? How do we help them put that back in place? That's our job. We don't implement it, but we try to make sure, well okay we have the gap, the funding loss, this went away, we need it. How do we get it back?"* • *"We had them written into some grants we got in the past."*
Coalition Role – Information / Training	• *"…there are other staff as well who can provide training on evidence-based strategies. So if an agency wanted to learn how to do a strategy or had questions, or needed some technical assistance, you know maybe they implemented something and they had questions, we can provide support by offering, you know providing training for their staff to assist with that."* • *"They come to the coalition. Because they present to the coalition about what they are doing and showcase what they're doing, because they do the programs. What programs they are putting in place."* • *"We'll go out and get trained on things and find out about it. I wanted asked the lady at [agency] to come speak to us. That's how we kind of draw that in, in case some of the groups within our community want to use that same program."*
Positive Attitudes	• *"The emphasis on evidence-based I absolutely get, you know data is data. Good science is good science. You have to be able to prove what you said you were going to do actually did what it was supposed to do."*

Table 8 Continued. Evidence-Based Practice Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Challenge – Resources	• *"…we can do it with minimum resources, i.e. money, though staff time might still be used, community time and energy might be used, but if it's not money that's needed, then the evidence doesn't necessarily have to be there for us to start doing it."* • *"It costs a lot of money… you have to buy the workbooks for each student. So you get the curriculum and you train people…But every year you would have to buy their research-based books...so one of my real criticisms, strong criticisms, of research-based…the ideal way to do research-based curriculum is what they did in [county name]. Every school got it, every kid got it, you inoculated the whole population of seventh and eighth grade kids, and then you revisited it. In this County, because there are 350,000 population, you've got eight high schools and I don't know how many junior highs. They pick one school. They will pick one school that has the worst… There's a lot of research to show it's not just the poor kids. It's across the board. It's kids. They are all seeing the same media messages. They are all in the same world. But that's the criticism of research-based. Yes it's great to have research-based. Yes it's great to implement it with fidelity, and train everybody, using stuff, but it's a financial issue. Who can do that?"*
Challenge – Buy-In	• *"…we like knowing that there's data behind something that somebody did, but sometimes we have to do what the community has the buy-in to do…"* • *"I can come in with the program and say this has worked in Wisconsin, so we should do it to. And they [referring to coalition members] say but we're not Wisconsin...So we need to get their buy-in. I use the group to make decisions and to kind of come up with a plan. If I can find something that is evidence-based that we can align it with, fantastic. If not, we will do the buy-in, do the assessment, and will show in our evaluation whether or not it worked."*
Challenge – Lack of Programs	• *"…there aren't a lot of evidence-based programs out there for community mobilization."* • *"We start with the evidence-based, but our problem is that most environmental strategies have not gone through that, have not received the holy grail stamp of approval from anybody in particular."* • *"…there's not a lot of evidence-based environmental strategies specific to prescription drugs in migrant communities. In this niche. You have to pull from the best of what you know and go."*
Challenge – Fit	• *"…you're trying to pretzel something into an environment where it really wasn't designed for…"* • *"You know there could be a great program, but maybe it's made for a certain type of clientele. I'm just guessing, but let's say there might be a large Hispanic population. The program might not work as well with them."* • *"…what works in the Latino population will not necessarily work with migrant Latino populations and we have a huge migrant population in [County]… As much as possible we go with the holy Grail, but there's not a lot of evidence-based environmental strategies specific to prescription drugs in migrant communities. In this niche. You have to pull from the best of what you know and go."* • *"…working with communities is like working with ameba. They keep branching out…and you just try to corral that and see if it works for this community, it's really tough. We do all the research and sometimes I think we just go with our best guess. Because that's all you have."* • *"You just can't expect the same results…You know we're doing this program, it's evidence-based, we'll follow it with fidelity, but we're doing it in an environment that it was not originally designed to do, and we expect these problems, these barriers and this shift in outcomes."*

Implementation

Coalition member and leadership knowledge and attitudes regarding effective program implementation were also assessed through the member questionnaires and leadership interviews. Identified implementation themes and representative quotes are described in Table 9.

Coalition member questionnaire. In the surveys, 83% of coalition members reported that training and technical support for program implementation is useful to a great or very great extent. Additionally, 54% of members reported that they agreed to a great or very great extent that coalition resources should be used to monitor the implementation of prevention programs. As discussed earlier and shown in Table 7, coalition member positive attitudes toward implementation training and monitoring were significantly correlated with member positive attitudes toward EBP. Positive member attitudes toward implementation was also significantly correlated with lower perceived levels of coalition conflict and difficulties associated with coalition participation and more positive attitudes and experience with prevention programs.

Key leader interviews. Leader interviews included several items intended to examine leader's knowledge, attitudes, and experiences with program implementation. Table 9 includes several identified interview themes related to program implementation and associated leadership quotes.

***Knowledge*.** Coalition leaders possessed varying levels of knowledge regarding successful program implementation. Leaders from three of the four coalitions used the word "*fidelity*" when describing EBP implementation. Several leaders emphasized that implementation fidelity is an important component of EBP: *"it is research-based, you have to implement it with*

fidelity." Leaders were able to identify several benefits of implementation monitoring. Two coalition leaders indicated that implementation monitoring can lead to better use of resources. Three of the coalitions discussed benefits of implementation monitoring related to adhering to identified goals and increasing accountability. Additionally, three coalition leaders emphasized the ability to identify and make needed changes or adjustments to the program or implementation process, using phrases such as "*course correction*". Leaders were also able to identify several factors that can enhance the successful implementation of programs or strategies.

One coalition leader discussed the importance of EBP and implementation training, having knowledgeable and effective leaders, and establishing a plan prior to implementation. Another leader discussed the benefits of low staff turnover when implementing a school-based prevention program.

Experience. Coalition members made several statements regarding their experience effectively implementing programs. When describing how coalitions implement programs or strategies, several leaders discussed following implementation guidelines or recommendations. All coalitions made some sort of statement regarding implementation monitoring, often in reference to monitoring their larger progress towards overall goals and objectives. Several leaders also discussed specific committees or workgroups charged with monitoring strategy implementation. All coalitions also discussed instances of training they have provided or attended to facilitate program implementation. Finally, one common theme articulated by several leaders when asked about implementation monitoring was a lack of responsibility or a lack of involvement. According to several leaders, because they do not directly implement many EBPs, responsibility relating to implementation quality lays with the partner directly implementing the

program. Similarly, a lack of awareness around implementation practices by partners was articulated by several leaders.

Attitudes. Most coalition leaders indicated general positive attitudes toward high-quality implementation of prevention programs and strategies. Three of the four coalitions emphasized the importance of fidelity in producing better outcomes. Several challenges to program implementation were discussed. One leader discussed issues that can negatively impact implementation fidelity related to the everyday challenges that occur in real-world, uncontrolled, settings. Another leader discussed high financial costs associated with implementation training and monitoring.

Table 9. Implementation Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Fidelity as a Component of EBP	• *"…fidelity is involved…you have to repeat however it was carried out."* • *"…you try to implement them with fidelity to get the same level of effectiveness."* • *"it is research-based, you have to implement it with fidelity"*
Implementation Monitoring –Better Use of Resources	• *"Monitoring the implementation of a program would achieve possibly better results…or better use of resources. So if this program is not implemented anywhere near what it was supposed to be, then perhaps we need to reevaluate where we're going with that."* • *"Sometimes if you're not paying attention, you can't let a program go. If the resources that you are expending, fiscal, staff, if it taken more time than we thought it would, because it affects everything else"*
Implementation Monitoring – Accountability	• *"There's some accountability. It's all well and good to have great goals, but if you're not monitoring them…If it doesn't seem to work when push comes to shove, you redesign. If you're not looking at it, reviewing it, then you don't know if it's working, or if it's not working if you need to change course, if you need to make revisions."* • *"I think if each agency is monitoring that process they can be sure that the audience, whoever that is, is receiving the best information, the accurate information, or an accurate process to impact them."*
Implementation Monitoring – Making Adjustments	• *"…making sure you're heading on the right track, also checking to see if you need to do a course change. If you are implementing something and it's not going well, what do you need to do to change it to make it go well? So making a course correction."* • *"Monitoring is also going to allow you, if you're agile and flexible, to adjust. ...there are environmental factors or staffing issues that you can adjust."* • *"…it is part of your evaluation process…do we need to make a course correction here? Do we need to change something? Would something be more effective?"*

Table 9 Continued. Implementation Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Enhancing Implementation: Training	• *"…trying to remain faithful to that requires incredible training. You really do need to know what that whole program is supposed to look like so you get it, and the people that are supposed to implement it get it."* • *"So you get the curriculum and you train people."*
Enhancing Implementation: Implementation Plan	• *"You can't just let it loose. There are benchmarks, and you really need to establish what those are, what you're looking for, and then follow it. There has to be in implementation plan, which is part of the evidence-based strategy."*
Enhancing Implementation: Leadership	• *"The biggest issue is training for the people who are doing the implementation and supervision. You really need to have someone who has the overall picture in is going to know the benchmarks and be honest about outcomes."*
Enhancing Implementation: Low Staff Turnover	• *"…training has not been an issue because staff are already familiar with it, and they have been implementing it for five years or more…we have had several long-term staff…"*
Implementation Experience: Following Guidelines	• *"if we're going to implement [program], I'm going to go to the database or the site and look at the way that they tell me is the best, most comprehensive manner to implement a strategy. I think the word comprehensive is really important. You are not just relying on one strategy."* • *"we do follow the guidelines when we can, as a coalition when we're implementing it."* • *"we make sure that they are done the way they were told in research. We don't do specific programs, so there is not a guidebook that guides you…but there are research papers that tell you what is effective, and what works, and how. So we do it according to the research."*
Implementation Experience: Monitoring	• *"…within our subcommittees we have logic models, we have goals, we have target dates. So were monitoring those plans."* • *"…we had objectives, so following through and making sure, monitoring those, to make sure that were doing what we said we would do."* • *"One way we monitor it is really just by word-of-mouth."* • *"…continuing monitoring of them. Making sure that they are monitored correctly. That's why we have our workgroups, they help monitor that."* • *[in reference to a specific strategy] "They tell us how many screens, how often, all that good stuff. Numbers. So you know how many views, how many people are seeing it. We ask our coalition members, have you seen it? What is the message that it's carrying?"* • *"Have you heard about KIT solutions? That's the way they monitor it"*
Implementation Experience: Training	• *"…We've done that through CMCA. We had training in that, two-day trainings happened twice. So four days of training altogether. Staff and volunteers in the community have been a part of that…"* • *"Our staff did [received training], the police officers. I'm sure [coalition] did to ensure that they could implement it correctly."* • *"…a lot of training for it, for some of the adults it was the second or third year they had that training."*
Implementation: Lack of Responsibility	• *"I don't implement the program. That is up to them."* • *"Each agency is responsible that they're implementing it correctly."* • *"The implementation process really falls on the agency that is implementing that."*
Lack of Awareness	• *"I really don't know. I assume that they are, but I don't know, I really don't know that much about it."* • *"I don't know exactly how they do it."* • *"I'm not 100% sure about how they monitor the outcomes or anything."*

Table 9 Continued. Implementation Themes Identified through Coalition Leader Interviews.

Theme	Representative Quote(s)
Positive Implementation Attitude	• *"…and you know you can't take shortcuts. If you're going to do it, you have to do it right."* • *"Monitoring saves your butt, that's what it does. You don't want to spend a year on a project just to find out that it's totally screwed up. You have your benchmarks, you meet monthly, you talk about what's working or not working, you make adjustments. How could you not monitor? I don't get that."* • *"it's in their best interest as well as the kids to implement it that way."* • *"This last year was not as successful… because there was no fidelity to the curriculum. So it was like yeah, it worked when we did it the way we were supposed to, it didn't work when we didn't. So guess what, the proof is in the pudding."*
Implementation Challenge – Real World Setting	• *"Realistically, I don't know anything that runs at 100% fidelity. Because stuff happens. The person you trained to put it in place got sick after three months and went away, and now you have a new person."*
Implementation Challenge - Costs	• *"Yes it's great to implement it with fidelity, and train everybody…but it's a financial issue. Who can do that?"*

CHAPTER FIVE:

DISCUSSION

The aims of the current research were to provide several different examples of how community-based substance abuse coalitions are organized and function, to describe community coalitions' perceptions and use of evidence-based practices (EBPs) and high-quality program implementation, and to identify coalition characteristics and/or attitudes associated with coalition adoption and successful implementation of EBPs. As part of this research, a mixed-methods study approach was undertaken, including coalition member surveys and semi-structured coalition key leader interviews. The current approach resulted in the development of several case examples of community substance abuse coalition functioning, contributing to the body of knowledge related to the organization of community-based coalitions. Further, surveys and interviews revealed several belief patterns surrounding coalition adoption and implementation of EBPs. The present study builds upon previous research that has examined coalition adoption of EBPs within specific coalition structure frameworks (Brown et al., 2010; Brown et al., 2013; Spoth, Guyll, et al., 2007) and has several implications for future research, community practice, and policy.

Coalition Functioning

The first aim of the current study was to examine coalition functioning and describe similarities and differences in functioning across several community substance abuse coalitions.

In the coalition member questionnaire, respondents across coalitions reported very high levels of coalition functioning across all of the included domains. No significant differences in rated functioning appeared across coalitions. These results are different than what was originally hypothesized: that perceived functioning would differ across coalitions. However, several explanations may account for the observed results.

Small sample sizes were obtained for each of the coalitions, limiting the present researcher's ability to make precise comparisons. In addition, because many of the surveys were completed at coalition monthly meetings, it is possible that participation was skewed to those coalition members with more positive perceptions of their coalition, as demonstrated through their active involvement in meetings. However, additional surveys were sent out to coalition membership through email in an attempt to reach other members. These findings could also be a limitation of the survey instrument itself. Because member responses were overwhelmingly positive, little variance in data was present. However, the questionnaire used was adapted from one of the only coalition functioning instruments whose psychometric properties has been tested and published (Brown et al., 2012). Although the questionnaire is still in the early stages of application, there are several strengths to its use in the current study. The questionnaire was developed and refined through six years of data collection and was specifically developed to identify empirically distinct subscales of coalition functioning, facilitating the examination of specific aspects of a coalition's functioning that contributes to outcomes (Brown et al., 2012). Further, tests of construct validity have supported the measure's use in coalition research (Brown et al., 2012). A final possible explanation for the present findings may be that coalition functioning is high across the included coalitions. This explanation is certainly plausible, as all four coalitions have been established within their communities for several years and have all

been awarded funding through the Drug Free Communities (DFC) program, indicating high levels of coalition capacity. As demonstrated through the interviews, coalitions were also structured similarly, focused on similar substance use topics, and used many of the same prevention strategies.

Coalition leader interview results similarly indicated high levels of functioning across coalitions. The interviews also provided specific examples of the coalition functioning domains in action, contributing to our understanding of coalition structures, processes, leadership, and synergy outlined in the CCAT framework (Butterfoss & Kegler, 2002, 2009). The provided case description and comparison sections illustrate how leaders perceive coalition activities. Further, although the coalitions were shown to function similarly, differences in lead agency type, sector representation, and engagement of key community sectors (e.g., law enforcement vs. behavioral health provider vs. local government) was shown to affect which activities coalitions focus on and perceived coalition challenges. Although coalition sector representation and lead agency support has been shown to influence coalition effectiveness in the literature (Hays et al., 2000; Jasuja et al., 2005; Zakocs & Guckenburg, 2007), no identified study has illustrated how differences in sector involvement influences coalition activities.

Evidence-Based Practice and Implementation

The second and third aims of the current study involved the examination of coalition member attitudes and use of EBPs and the identification of potential functioning characteristics associated with positive attitudes and adoption of EBPs. Coming back to these two aims, coalition member surveys revealed general positive member attitudes toward EBP. Additionally, community support and perceived participation benefits were shown to be significantly

correlated with member positive EBP attitude. These findings are in line with previous research on coalition support of EBPs and the original study hypothesis that relationships between coalition functioning domains and EBP adoption and implementation exist. Brown and colleagues (2010) found that CTC coalitions reporting stronger community relations were more likely to support the high-quality implementation of EBPs. These findings also illustrate the need for coalition buy-in in EBP and prevention planning. As illustrated in the previous chapter, several interview participants emphasized the influence of community support and buy-in on coalition decision-making (e.g., "*…we like knowing that there's data behind something that somebody did, but sometimes we have to do what the community has the buy-in to do…*"). This conclusion is supported by the survey findings, identifying a positive association between perceived coalition participation benefits and member support of EBPs. Perceived benefits of participation has been shown to be related to member recruitment and level of involvement in the literature (Chinman & Wandersman, 1999). Additionally, this construct has been theoretically hypothesized to be negatively related to member attrition and positively related to community support, program implementation, and coalition sustainability (Brown et al., 2012). Even if coalition leaders attempt to support EBP implementation, if coalition member attitudes are not in line (i.e., member buy-in is not present), coalition membership could be negatively impacted. Attitudes toward implementation training and monitoring was also found to be positively correlated with EBP attitude. Not only do most coalition members support coalition or partner use of EBPs, but they also believe, to at least some extent, that coalition resources should be used to support quality implementation. This finding supports the notion that coalition support of high-quality EBP implementation can be achieved (Fagan et al., 2008a, 2008b, 2009; Spoth, Guyll, et al., 2007).

Leadership interviews identified several other coalition belief patterns surrounding EBP and implementation. Nearly all coalition leaders demonstrated at least a basic understanding of EBP and supported the need to adopt EBPs within their communities. This finding suggests that recent efforts undertaken by governmental and other funding agencies to support EBP translation have been successful at increasing community awareness. However, varying levels of sophistication in responses regarding EBP and implementation suggest additional knowledge gaps.

All coalitions emphasized that they do not implement programs, but focus on evidence-based environmental strategies. Most of the current EBP databases available (e.g., NREPP) focus on implementation in more traditional settings (e.g., schools). The complexity of environmental strategies and challenges associated with conducting high-quality research to evaluate environmental strategies means that coalitions are left with fewer options in EBP selection. However, several environmental strategies have undergone rigorous testing and have been shown to be effective. The Centers for Disease Control and Prevention publishes a Community Guide with information on programs and environment strategies shown to be effective based on systematic reviews of current research (see http://www.thecommunityguide.org/). Most of the environmental strategies with "strong" levels of evidence target underage alcohol or tobacco use and typically involve local or state policy change (CADCA National Coalition Institute, 2010). Coalition leaders did discuss several "promising" environmental strategies in their interviews (e.g., responsible beverage service training, social host laws, and compliance checks) (CADCA National Coalition Institute, 2010).

CADCA has identified several environmental strategy-focused EBPs that can be effectively implemented by community coalitions (CADCA National Coalition Institute, 2010).

These programs include: *Communities Mobilizing for Change on Alcohol* (CMCA) (Wagenaar, Murray, & Toomey, 2000); *Community Trials Intervention to Reduce High-Risk Drinking* (Holder et al., 2000); *Tobacco Policy Options for Prevention* (TPOP) (Forster, Wolfson, Murray, Wagenaar, & Claxton, 1997); *Border Binge Drinking reduction program* (Voas, Tippetts, Johnson, Lange, & Baker, 2002); and *Challenging College Alcohol Abuse* (Glider, Midyett, Mills-Novoa, Johannessen, & Collins, 2001). Three of these programs are listed on the NREPP website. Although the fourth program, TPOP, was not listed on NREPP, a randomized community trial of the program showed increases in tobacco control policies and decreases in youth smoking within intervention communities (Forster et al., 1997).

The goal of the current study was not to suggest that other coalition activities, unrelated to evidence-based practice, are not important or helpful for coalitions or the communities they serve. As demonstrated through the interviews, participating in community events is important to members in building community awareness, establishing buy-in, recognizing and celebrating coalition successes, and fueling member passion. However, preventing substance use across entire communities requires environmental strategies and prevention programs that target conditions across multiple levels of risk (e.g., individual, family, organizational, and community levels) (Hawkins et al., 2002). CADCA recommends the implementation of an array of approaches, including both individually-focused prevention programs and environmentally-focused interventions (CADCA National Coalition Institute, 2010).

Study Limitations

There were several limitations of the current study, in addition to the survey and sample size limitations already discussed. Because the survey instrument was disseminated via email by

coalition leaders, the exact response rate cannot be determined. However, given the large member sizes described by leaders, it is likely that the response rates across the coalitions were low. The current study also relied on self-report survey and interview data. It is likely that social desirability bias was present to some degree, causing coalition members and leaders to over-estimate the levels of functioning present within their coalition. This concern was partially mitigated throughout the analysis of interviews by considering both articulated and attributional data (Massey, 2011). Specifically, the sophistication of responses was used as an indicator of functioning on several occasions. For example, even though leaders describe communication and cohesion positively, the current analysis additionally searched for specific examples of positive member relationships and the types of communication methods used, possibly limiting the effects of this type of response bias. Additionally, the cross-sectional nature of the surveys makes inferences regarding the causal relationship of identified relationships impossible. However, interview responses provide additional insight regarding the relationships identified through the member surveys, such as the relationship between perceived participation benefits and EBP attitudes discussed earlier.

An additional limitation is that only two individuals, both serving leadership positions, were interviewed from each coalition. An issue of interview representativeness could be present (Miles & Huberman, 1994). However, the purpose of the interviews was to gain insight into perceived coalition functioning and decision-making from key coalition leaders. The included interview participants from each coalition (the coalition chair and director or coordinator) represented two of the most influential leaders within each coalition. Individuals serving in these positions have been involved with their coalition for an established period of time, are knowledgeable about coalition organization and activities, and generally participate in all key

coalition decision-making. The current study also attempted to triangulate results through the inclusion of two separate individuals from each coalition and by employing multiple methods of data collection (Miles & Huberman, 1994). Further research efforts, however, may gain additional insights by conducting similar interviews across a broader group of coalition members.

Researcher effects could have also been present in the current study. All data collection was conducted by one researcher with a previous history working with two of the four included coalitions. It is possible that this prior experience could have interfered with data collection or analysis. In data collection, however, the researcher closely followed a semi-structured interview guide and audio recorded all completed interviews, enhancing the dependability of the interview results (Guba, 1981). Although interview coding was primarily completed by the present researcher, a separate coder did independently code one of the interviews to assess coder agreement and evaluate the utility of the developed codebook. Additionally, direct quotes from interviews were provided throughout the write-up of the study results to illustrate key points and to enhance the credibility and confirmability of the findings (Guba, 1981).

In addition to small survey and interview sample sizes, only four community coalitions who have all received DFC funding participated in the current study. Conclusions cannot be generalized to all substance abuse coalitions across the United States. Further, included coalitions were all located in a similar geographic region. The close proximity and collaborative nature of coalitions introduces the possibility that members of the participating coalitions communicated with each other about activities, or even about their participation in the current study, introducing a form of contamination bias into the study. A larger study, examining coalitions across the country, including both DFC-funded and non-funded coalitions, would be

helpful to further understand the relationships between coalition functioning and implementation of EBPs. Despite all of these limitations, the current research was successful in producing four detailed case examples of how community substance abuse coalitions function within their communities. Additionally, the results of the current study revealed several beliefs coalition leaders have regarding EBP and implementation.

Directions for Future Research

The current study findings have implications for the direction for future research on community-based substance abuse coalitions and evidence-based practice. Community buy-in and support emerged as an important theme on several different occasions, representing a major influencing factor regarding coalition adoption and quality implementation of EBPs. Building community support also emerged as a major coalition challenge across both surveys and interviews. The current study focused on coalition member perceptions of coalition functioning and attitudes toward EBP. Additional research to examine awareness and attitudes of outside community leaders towards coalition activities and use of EBP would be beneficial to further understand coalition functioning and to identify strengths and/or challenges related to community engagement and buy-in.

Additionally, although most members were familiar with the term *evidence-based*, they often applied it differentially to various coalition strategies. For example, some leaders used the term in reference to broad environmental strategies whose effectiveness has not fully been evaluated. Another leader described programs that they developed themselves as "*evidence-based*" if they were able to show positive outcomes in a local evaluation. Researchers should be careful when using the term *evidence-based* when working with coalitions or other community-

based groups. To ensure researchers are measuring the intended phenomena, it is important that they clearly understand how these terms are perceived by their target population.

One of the major EBP criticisms articulated by coalition members was the lack of evidence-based programs and environmental strategies relevant to their unique community circumstances. Future research to evaluate current environmental strategies and to develop additional community-focused interventions is needed to address these concerns. Methods employing the principles of community-based participatory research, including the coalitions themselves in the research process (Wallerstein & Duran, 2010), would be helpful in designing, implementing, and evaluating strategies and programs that fit coalition needs and capacities. Further, although the current study was able to identify several challenges associated with coalition adoption and implementation of EBPs (e.g., resources, buy-in, fit), additional research including a larger sample of coalition leaders would be beneficial to fully explore perceived coalition challenges. For example, because the current study was able to build a base of knowledge regarding this subject, future research might employ a Delphi Technique (Hsu & Sandford, 2007) to assess and prioritize coalition experts' perceptions of EBP facilitators and challenges.

Finally, the current study has some implications regarding the utility of the Community Coalition Action Theory (CCAT) for future research. The CCAT framework was very helpful for the purposes the present study in organizing and identifying important functioning constructs of interest. Additional research, identifying specific measurement constructs related to the separate CCAT domains, would be beneficial for future research and for further evaluation of this theoretical framework. The CCAT model explains how the various identified domains relate to the successful implementation of planned strategies, although these strategies are not specific to

EBP. For the purposes of the present study and future research related to coalition adoption of EBPs, modifications might be made to the CCAT framework that include theorized mechanisms related to planning and successful implementation of EBPs. Such alterations could be helpful for researchers and community members in the future conceptualization and measurement of EBP implementation in relation to coalition practice.

Implications for Community-Based Prevention

Coalitions are uniquely situated to address several of the traditional challenges associated with the high-quality implementation of EBPs in community settings. They are deeply rooted in the community. Coalitions understand what the current problems are within their communities and are able to build community buy-in and support of selected strategies, as illustrated throughout leadership interviews. Coalitions also represent an opportunity to coordinate EBP implementation and facilitate systems-level support for a program or strategy, a key "driver" of successful program implementation (Fixsen, Blase, Naoom, & Wallace, 2009). However, as identified through the key leader interviews, several challenges still exist that are inhibiting full coalition support of such strategies. Additionally, although a program's evidence-base was identified as an important influencing factor in coalition decision-making, coalition leaders identified several other factors they consider when identifying new strategies to implement. Perceived fit of the strategy with the coalition's vision and member support or buy-in may be the most important influencing factors identified by leaders.

Future efforts are needed to work with coalitions and community efforts to build their knowledge base and support of evidence-based prevention strategies, with a special emphasis on bringing information about EBP and implementation to the community. Community workshops,

trainings, and technical assistance opportunities are needed to build this knowledge. Previous research has suggested that training and technical assistance can positively impact coalition support of EBPs (Feinberg, Greenberg, Osgood, Anderson, & Babinski, 2002; Spoth et al., 2004). Additionally, most coalition leaders described the recruitment of speakers for coalition meetings in the interviews. EBP and implementation experts could work with coalition leaders to present some of this information directly to coalitions at regularly scheduled meetings.

The current study also has several funding implications. Recall that the Drug Free Communities (DFC) program remains the current top source of coalition funding in the United States (ONDCP, 2014). Currently, the DFC funding program has requirements related to the implementation of several of the seven change strategies outlined by CADCA (CADCA National Coalition Institute, 2009). However, no such requirement exist regarding the evidence-base of identified strategies. Several coalition leaders defined the seven change strategies as "*evidence-based"* in their interviews. However, a range of different interventions, containing differing degrees of known effectiveness, can be employed by coalitions to fall in line with the CADCA strategies. Additional policy or funding requirements, outlining strategies with higher levels of known effectiveness, may be beneficial at expanding coalition use of effective interventions.

Conclusions

As the emphasis for prevention efforts that target adolescent substance use issues at the community-level increases, community coalitions are growing in popularity. The current study provided several examples of real-world community substance abuse coalitions in action. Several factors were shown to influence coalition decision-making processes and overall functioning. In addition, the present study highlighted strengths and gaps related to coalition leadership

knowledge, attitudes, and implementation of evidence-based programs and strategies. With their growing popularity, it is likely that community coalitions will take on a major role in future community-based prevention efforts across the country. As such, there is a need to design substance use prevention programming with coalitions in mind and to identify alternative avenues to disseminate information surrounding community-focused EBPs. The current research also suggests that relationships between coalition functioning and use of EBPs are present. Identifying new ways to measure and build coalition processes, leadership skills, and structures identified through CCAT could result in greater coalition capacity to plan for and support prevention activities, including their use of EBPs.

CHAPTER SIX:

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APPENDIX A

Community Coalition Survey

Please fill out each question the best you can. In most cases, please circle or check your choice of answer. In some cases, please fill in your answers as concisely as possible.

A. Background

1. Which county does your coalition serve?: _____

2. Which best describes your role in this coalition?

- ❍ Board chair / co-chair
- ❍ Other board member
- ❍ Other staff person
- ❍ Regular member
- ❍ Other

3. In which occupational sector do you work?

- ❍ Business
- ❍ Education
- ❍ Local Government
- ❍ Health Services
- ❍ Public Human Services
- ❍ Private Human Services
- ❍ Judicial System
- ❍ Law Enforcement
- ❍ Faith Community
- ❍ Concerned Citizen (not affiliated with any of the above)

4. What is your official position at work? _____

5. Is your agency involved in the implementation of any youth-focused prevention programs?

❍ Yes ❍ No

B. Coalition Involvement

6. For how long have you been a part of this coalition? ____Years ____Months

7. Over the past 12 months, approximately what percentage of the coalition meetings have you been able to attend? Would you say…

○ Less than 25% ○ Between 25-50% ○ Between 50-75% ○ Between 75-100%

8. What kind of roles have you played in the past 12 months in your local coalition? In the past 12 months, did you...

a) Talk at meetings (make comments, express ideas, etc.) Yes No
b) Serve as a member of a committee Yes No
c) Chair or lead a committee or sub-group Yes No

9. About how many hours, in an average month, have you given to the coalition for the following activities? Please fill in the number of hours for each activity per month:

a) _____Hrs. Meetings including both general coalition meetings and subcommittee meetings

b) _____Hrs. Work outside of Meetings

10. How much influence do you feel you have on your coalition's decisions?

○ No Influence ○ Some Influence ○ A Lot of Influence ○ A Great Deal of Influence

C. Coalition Functioning

11. Please answer the following questions to describe your experience of coalition meetings over the past year.

	Strongly Disagree		Somewhat Disagree		Somewhat Agree		Strongly Agree
a) This is a highly efficient, work-oriented team.	1	2	3	4	5	6	7
b) Team members work very hard.	1	2	3	4	5	6	7
c) People pay a lot of attention to getting work done.	1	2	3	4	5	6	7

12. How skilled is your coalition chair in the following areas?

	Needs Work		Adequate		Strong		Very Strong
a) Interpersonal and communication skills	1	2	3	4	5	6	7
b) Organizational skills	1	2	3	4	5	6	7
c) Enthusiasm and passion for the coalition mission	1	2	3	4	5	6	7
d) Understanding and knowledge of prevention	1	2	3	4	5	6	7

13. Please rate the communication between your coalition chair and board members on the following scales:

a) Frequency of communication

Infrequent		Somewhat Infrequent		Somewhat Frequent		Frequent
1	2	3	4	5	6	7

b) Productivity of communication

Unproductive		Somewhat Unproductive		Somewhat Productive		Productive
1	2	3	4	5	6	7

14. Below is a list of some goals for a coalition board. For each one, choose how far the board has progressed to date.

	No		No, but working on it		Yes, to a limited extent		Yes
a) The Board has agreed on how it will govern itself, make decisions, and clarify the roles of members.	1	2	3	4	5	6	7
b) The Board has developed clear goals and objectives.	1	2	3	4	5	6	7

15. Consider the following statements about the leadership of your coalition over the past year. For each statement, check how much you agree or disagree with that statement.

The coalition leadership:	Strongly Disagree		Somewhat Disagree		Somewhat Agree		Strongly Agree
c) Creates an environment where differences of opinion can be voiced.	1	2	3	4	5	6	7
d) Intentionally seeks out your views.	1	2	3	4	5	6	7
e) Asks you to assist with specific tasks.	1	2	3	4	5	6	7
f) Has a clear vision for the coalition.	1	2	3	4	5	6	7
g) Is respected in your community.	1	2	3	4	5	6	7
h) Is able to mobilize resources to aid the coalition.	1	2	3	4	5	6	7
i) Has the political knowledge and competence to support the coalition.	1	2	3	4	5	6	7
j) Is skillful in resolving conflict.	1	2	3	4	5	6	7
k) Adheres to decision-making procedures that the coalition has adopted (for example, by-laws, voting procedures, member roles and positions)	1	2	3	4	5	6	7

16. Some coalitions have to deal with conflict and tension caused by differences of opinions, personality clashes, hidden agendas and power struggles.

	A Lot		Some		Not Much		None
a) In the past 12 months, how much or how little tension have you noticed?	1	2	3	4	5	6	7
b) In the past 12 months, how much or how little conflict have you noticed?	1	2	3	4	5	6	7

17. How much do you agree or disagree with the following statements about your coalition?

	Strongly Disagree		Somewhat Disagree		Somewhat Agree		Strongly Agree
a) There is a feeling of unity and cohesion in this coalition.	1	2	3	4	5	6	7
b) There is not much group spirit among members of this coalition	1	2	3	4	5	6	7
c) It is difficult to develop a sense of trust with other board members.	1	2	3	4	5	6	7
d) There is a strong feeling of belonging in this team.	1	2	3	4	5	6	7
e) Members of this team feel close to each other.	1	2	3	4	5	6	7

18. Please answer the following questions regarding your community's support:

	No		A Little		A Good Amount		A Great Deal
a) Do influential community leaders understand the coalition and why it is important?	1	2	3	4	5	6	7
b) Does the administrative leadership in the school system support coalition activities?	1	2	3	4	5	6	7
c) Does the administrative leadership in participating community agencies support coalition activities?	1	2	3	4	5	6	7
d) The coalition board has collaborative relationships with other key community institutions and coalitions.	1	2	3	4	5	6	7

19. How much benefit have you gained from your involvement with the coalition in these areas:

	Not at All		A Little		Some		A Great Deal
a) …learning new skills?	1	2	3	4	5	6	7
b) …developing valuable relationships?	1	2	3	4	5	6	7
c) …feeling a sense of personal	1	2	3	4	5	6	7

fulfillment in working to improve your community?							

20. How much has your involvement with the coalition interfered with:

	Not at All		A Little		Some		A Great Deal
a) …your work schedule and responsibilities?	1	2	3	4	5	6	7
b) …your family life?	1	2	3	4	5	6	7
c) …your personal free time?	1	2	3	4	5	6	7

D. Coalition Prevention Programming

21. Please rate the extent to which you agree with following statements regarding youth prevention programs.

	Strongly Disagree		Somewhat Disagree		Somewhat Agree		Strongly Agree
a) School based prevention programs that include families can reduce the prevalence of youth substance use.	1	2	3	4	5	6	7
b) Substance use prevention programs are a good investment.	1	2	3	4	5	6	7
c) I am familiar with specific substance use prevention programs.	1	2	3	4	5	6	7
d) I am familiar with the term "evidence-based program".	1	2	3	4	5	6	7
e) I am familiar with specific evidence-based substance use prevention programs.	1	2	3	4	5	6	7

22. The following questions ask about your feelings about your coalition or coalition partners using new types of substance use prevention programs. Circle the number indicating the extent to which you agree with each item.

	Not at All	To a Slight Extent	To a Moderate Extent	To a Great Extent	To a Very Great Extent
a) I would like my coalition or partners to use new programs to reduce youth substance use.	1	2	3	4	5
b) I would support coalition or partner use of new types of programs, even if they have to follow a manual.	1	2	3	4	5

c) I know better than academic researchers how to address youth substance use in my community.	1	2	3	4	5
d) I would support coalition or partner use of new and different types of programs developed by researchers to reduce youth substance use.	1	2	3	4	5
e) Services and interventions developed by researchers can benefit this community.	1	2	3	4	5
f) Professional experience is more important than research when it comes to youth substance use prevention.	1	2	3	4	5
g) I would not support coalition or partner use of manualized prevention programs.	1	2	3	4	5
h) I would support coalition or partner use of a new program to reduce youth substance use even if it were very different from what they are used to doing.	1	2	3	4	5
i) Coalition resources should be used to monitor the implementation of prevention programs.	1	2	3	4	5
f) Training and technical support for program implementation is useful.	1	2	3	4	5

Thank you for completing this survey. Please return the survey to the envelope provided.

APPENDIX B

Coalition Leader Pre-Interview Background Questionnaire and Interview Guide

1. How long have you been a part of this coalition? ____Years ____Months

2. How long have you been this coalition's chair or coordinator? ____Years ____Months

3. In which occupational sector do you work?

- ❍ Business
- ❍ Education
- ❍ Local Government
- ❍ Health Services
- ❍ Public Human Services
- ❍ Private Human Services
- ❍ Judicial System
- ❍ Law Enforcement
- ❍ Faith Community
- ❍ Concerned Citizen (not affiliated with any of the above)

4. What is the highest degree you have obtained?

- ❍ High school diploma
- ❍ GED
- ❍ A.A.
- ❍ Trade School
- ❍ Bachelor's degree
- ❍ Master's degree
- ❍ M.D., J.D., or other professional degree
- ❍ Ph.D.

5. What is your official position at work? _____

6. Is there anything else you would like to add about your professional background?

_____

_____

7. Please rate the degree to which represented community sectors are involved in coalition activities.

	Not Involved	Minimally Involved	Moderately Involved	Highly Involved
a) Youth	1	2	3	4
b) Parents	1	2	3	4
c) Business Community	1	2	3	4
d) Media	1	2	3	4
e) Schools	1	2	3	4
f) Youth-serving organizations	1	2	3	4
g) Law enforcement agencies	1	2	3	4
h) Religious or fraternal organizations	1	2	3	4
i) Civic and volunteer groups	1	2	3	4
j) Healthcare professionals	1	2	3	4
k) State and local and/or government agencies	1	2	3	4
l) Other organizations	1	2	3	4

8. Approximately how much funding did this coalition receive in the past year? _____

9. What were the sources of this funding? _____

Interviewer:	Date:	Start Time:	End Time:
Participant:			
Participant's Title / Role:			
Participant's Agency/Organization:			

(Potential prompts are italicized.)

Thank you for agreeing to participate in this interview. Let's begin by talking a little generally about this coalition's background, structure, and functioning.

Introduction/Background

1. Can you briefly describe how and why this coalition got started and how it is organized?
    a. *Was there a specific community agency that facilitated the coalition's establishment? If so, which one?*
    b. *What are the coalition's major goals? Have these changed?*
    c. *How is leadership managed within the coalition?*
    d. *Can you briefly describe the coalition's committees and workgroups, if any?*

Member Engagement

2. How would you describe the overall level of member engagement in this coalition?
3. How do you encourage the participation of existing coalition members and the acquisition of new ones?

Coalition Processes

4. Could you describe what typically occurs at a general coalition meeting?
5. How would you describe the communication between coalition members?
    a. How often do you think coalition members communicate with each other regarding coalition activities?
6. How would you generally describe the relationships between coalition members?
    a. Do members generally get along well with each other?
    b. Is there any conflict and how do/would you deal with conflict?
7. What generally guides your coalition's decisions in prevention planning?
8. Could you briefly describe the coalition's decision-making process?
    a. Who is primarily involved in this process?

Community Support

9. How would you describe the community's perceptions of this coalition?
    a. How do you gauge community support or the coalition and/or its activities?
    b. Could you describe how influential community leaders support coalition activities?

Now we're going to shift emphasis a little bit and talk about your coalition's perceptions toward youth prevention programming.

Prevention Knowledge/Attitudes

10. How do you identify and prioritize substance abuse needs in your community?
11. Please briefly take a look at the seven coalition strategies outlined by the Community Anti-Drug Coalitions of America (provide handout). Which of these strategies is your coalition involved in?
    a. *What seems to be the most important strategy(ies) to your coalition?*
    b. *Where has your emphasis been?*
    c. *Are there any other strategies not discussed in this handout that you have been involved in?*

Evidence-Based Practice and Implementation

12. For the purposes of your coalition, how would you define what constitutes an evidence-based practice or program?
13. If someone asked you for the names of a couple good prevention programs, where would you go to research effective prevention programs?
14. What kinds of information are important for you to decide if a prevention program is backed by good research?
15. What's your approach to making sure prevention programs are implemented as they were designed?
16. What have you found to be the best ways to decide if a prevention program is working well in your community?
17. What do you think monitoring the implementation of prevention programs achieves?

I appreciate all of your time to participate in this interview today. Now that I have some information about your coalition's background and perceptions toward prevention programming, I want to finish the interview by asking a couple questions about a practical example.

18. Can you name 1 or 2 prevention programs that your coalition is involved with and describe the population that these programs target?

For up to two programs:

19. How is your coalition involved in the implementation of [program name]?
    a. *For example, did you help in selection, provide consultation, are you a co-sponsor or helped obtain funding, or are you the primary sponsor?*
20. How do you monitor the implementation of [program name]?
21. Did the program staff receive training in delivering [program name]?
    a. *Was there any additional training, coaching, or technical assistance beyond this initial training for [program name]?*
22. Have I overlooked any relevant information that you would like to add?

APPENDIX C:

IRB APPROVAL LETTER

USF
UNIVERSITY OF SOUTH FLORIDA

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813)974-5638 • FAX(813)974-7091

June 2, 2014

Nichole Snyder
Community and Family Health
Tampa, FL 33612

RE: **Expedited Approval for Initial Review**
IRB#: Pro00017192
Title: A Case Description of Community Substance Abuse Coalitions

Study Approval Period: 5/31/2014 to 5/31/2015

Dear Ms. Snyder:

On 5/31/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
Coalition Study Protocol - V1 - 5.8.2014

Consent/Assent Document(s)*:
Interview - Informed Consent V1 - 5.28.2014 (**granted a waiver of documentation)
Survey - Informed Consent - V1 - 5.28.2014 (**granted a waiver of documentation)

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s). **Waivers are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board